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Patients' Perception and Experience of using Guided Self-Help for Depression and Anxiety in a Primary Care Setting

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TABLE OF CONTENTS

THESIS ABSTRACT

Objectives. There is a developing body of evidence that guided self-help can be effective in alleviating distress experienced from symptoms of depression and anxiety. However evidence is not consistently positive and clarification is required about how it achieves its effects. Furthermore, previous research into guided self-help has not investigated patients with milder depression or anxiety. Exploration of the therapy process in guided self-help has crucial importance in developing further understanding about its qualities and how it is experienced. This study aimed to explore the ways in which people experience guided self-help for depression or anxiety within primary care.

Design. Qualitative research has been recommended to complement the quantitative work that has been published to date on guided self-help. The data used for analysis was gathered from semi-structured interviews.

Method. Interpretative phenomenological analysis was used. Semi-structured interviews were carried out with seven participants who had accessed and completed guided self-help for either mild depression or anxiety. The verbatim transcripts of those interviews served as the data for analysis.

Results. Four themes emerged which are described under the broad headings: participants' intention to feel better, development of understanding and awareness, change: from dependency to independence, and relating to others.

Conclusions. Participants experienced a positive outcome of using guided self-help, which included increased knowledge about their thoughts and feelings, and increased self-efficacy in managing their own mental health. These findings shed light on how the patients' positive outcomes are related to the change process. Findings also suggest that self-determined motivation may impact upon accessibility to guided self-help in addition to patients' attitudes and expectations.

STATEMENT OF CONTRIBUTION

This is to declare that this thesis is the result of the author's own independent work, except where otherwise stated. For example, Dr. Rachel Sabin-Farrell helped with the focus and design of the study and provided the necessary contacts for recruitment of participants. Graduate mental health workers, Lian Dimaro and Neale Haddon were also involved in the recruitment process by providing potential participants with an information sheet about the study. This thesis has not been written or composed by another person and all sources have been appropriately acknowledged by giving explicit references. A detailed list of these references is attached.

I further declare that this work has not been previously submitted or accepted in the same form for any degree.

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Abstract

Objectives. Exploration of the therapy process in guided self-help has crucial importance in developing further understanding about its qualities and how it is experienced. The current study therefore aimed to explore patients' experience of guided self-help for mild to moderate depression or anxiety by examining: expectations of guided self-help, *how* it was experienced and any change that may have occurred.

Design. A qualitative research design was employed and the data used for analysis was gathered from semi-structured interviews.

Method. Interpretative phenomenological analysis was used and the verbatim transcripts of the interviews served as the data for analysis. Semi-structured interviews were carried out with seven participants who had accessed and completed guided self-help.

Results. Four themes emerged which are described under the broad headings: participants' intention to feel better, development of understanding and awareness, change: from dependency to independence, and relating to others.

Conclusions. Participants experienced a positive change outcome of using guided self-help, which included increased knowledge and self-efficacy in managing their own mental health. Findings also suggest that self-determined motivation may impact upon accessibility to guided self-help.

Introduction

Anxiety and depression are two of the most common psychological disorders in primary care (see extended paper 1.1 and 1.2 for definitions of depression and anxiety) with a national survey showing high prevalence (up to 10–15%) in the general UK population (Office of Population & Census Surveys, 2006). Guided self-help (GSH) has been recommended in the National Institute for Clinical Excellence (NICE) guidelines on anxiety and depression (2004), and research investigating its effectiveness suggests it can significantly improve levels of distress (Anderson *et al.,* 2005; Ekers & Lovell, 2002; Lovell, Richards, & Bower, 2003). Furthermore, GSH has been promoted as a key element of stepped-care models (Lovell & Richards, 2000; Scogin, Hanson, & Welsh, 2003) (see extended paper 1.3 and 1.4 for further information about IAPT and stepped-care).

'Self-help' is an umbrella term used to describe treatments requiring less reliance on therapist availability (Bower & Gilbody, 2005). It involves delivering Cognitive-Behavioural Therapy (CBT) techniques (see extended paper 1.5.1 and 1.5.4 for further information about CBT and its effectiveness) through a 'health technology' (Richards *et al.,* 2003) such as written material or information technology (Marrs, 1995; Proudfoot *et al.,* 2004). Although these technologies may be provided alone, they may also be facilitated through small amounts of therapist contact, described as GSH, which will be the main focus throughout this paper.

GSH is a structured approach requiring patients to act on advice provided within self-help workbooks, with additional support from a healthcare professional. Workbooks provide activities, worksheets and checklists for the patient to complete between sessions and focus on issues such as negative thinking, reduced activity and how to overcome practical problems. Additionally, patients are given instructions on how to improve their skills and confidence in self-management.

The effectiveness of self-help treatments has been investigated using reviews and meta-analyses and findings suggest that self-help can be more effective than no care. In particular, Bower, Richards, and Lovell (2001) completed a systematic review regarding the effectiveness of self-help treatments within a primary care setting and found that self-help resulted in significant benefits when compared with control groups (see extended paper 1.6 for further review of empirical literature). However, whilst benefits of GSH appear to be significant, there is some uncertainty surrounding the intervention. Notably, research findings suggest there are implementation issues due to patients' expectations of therapy and there is a lack of clarity about how it reduces levels of distress in patients.

Expectations of GSH

Within Scogin *et al's*. (2003) report describing a framework for treating mild to moderate depression, they acknowledge that patients may feel the provision of minimal intervention is inappropriate because it may feel as though their depression is being dismissed. Bower *et al.* (2001) also found that uptake rates for the offer of minimal intervention are limited. For example, one-fifth of patients motivated to return screening questionnaires to a clinic refused the offer of computerised self-help (Marks *et al*., 2003), and when patients were offered self-help whilst on a waiting list for CBT, only half took up the offer (Whitfield, Williams, & Shapiro, 2001). The issue of acceptability therefore raises possible tension between increasing clinical benefit using available resources and providing services that are patient-centred and meet current policy (Bower & Gilbody, 2005).

Effective implementation of self-help services might therefore be compromised by expectations (Priest, Vize, Roberts, Roberts, & Tylee, 1996). Rogers, Oliver, Bower, Lovell, and Richards (2004) used qualitative methods to explore patients understanding regarding the use of self-help clinics and conducted interviews as part of an evaluation.

They found that patients' experience of self-help was incongruent with prior expectations. Macdonald, Mead, Bower, Richards, and Lovell (2007) used qualitative methods to explore patients' attitudes towards GSH by examining expectancies of psychological therapy and experiences with GSH. They completed 24 semi-structured interviews during a randomised trial (with patients on a waiting list to receive psychological therapy for depression or anxiety) and analysed the data using QSR NUD.IST software. Their findings suggest that important gaps exist between expectancies of psychological therapy and actual experience of GSH in relation to therapy processes and outcomes. Unfulfilled expectancies were related to issues of time, processes of sharing personal problems, and gaining insight into the cause of their condition (Macdonald *et al.,* 2007). Whilst Macdonald *et al's*. (2007) study offers useful implications for the future use of GSH, their study recruited patients who experienced more moderate to severe depression. However, inclusion for GSH is for people with more mild depression or anxiety (Lovell & Richards, 2000).

Mechanism of Change

The primary focus of GSH is the reduction or remission of symptoms (Macdonald *et al*., 2007). Meta-analyses have been conducted on the outcomes of moderators to identify the components that make self-help effective (Gellatly *et al*., 2007) but results have been inconclusive. As GSH is based on CBT techniques it is assumed that the model of change would be similar to CBT. According to cognitive-behavioural theory, individual behavioural change can be facilitated by active modification of thoughts, which includes not only attainment of knowledge and skills to make a change but also a self-development component (Beck, Rush, Shaw, & Emery, 1979). This involves an individual being responsible for their own learning and development whilst enhancing understanding about their 'self' (see extended paper 1.5.2 for more information about therapeutic change). Furthermore, it is stated within

CBT that the therapeutic relationship is an important component involved in the change process (Beck, 1976). Whilst GSH assumes that change will be similar to that of CBT whereby individuals will experience a change in skills and cognitions, there is less emphasis on the therapeutic relationship within GSH (see extended paper 1.5.3 for more information about the therapeutic relationship).

Engagement with GSH is therefore associated with awareness of the 'self' being seen as the mechanism of change (Khan, Bowers, & Rogers, 2007). According to Bandura (1977), self-efficacy is an important factor in promoting behaviour change, as it can determine the choice of activities a person engages in and their dedication to such activities. This is particularly important within GSH as it refers to a person's belief in their ability to engage in intervention and manage their own symptoms. However, Rogers *et al.* (2004) found that there is tension between the need to develop the idea that the individual is the principal mechanism of change, which takes time, and the relatively short-term nature of contact within GSH. Furthermore, Rogers *et al.* (2004) noted that the presence of a therapist offering guidance created ambivalence in patients about the relative role of the therapist and their own use of self-help materials.

To summarise, this investigation addresses three issues raised by the increasing use of GSH. First, GSH may not be initially attractive due to people's 'expectancies' of therapy being fixed by particular ideas of therapy, which are different from GSH. Second, given the short-term nature of GSH and the assumption that meta-theories of change usually assume the presence of another person, how are effects achieved? Third, previous research into GSH has not investigated milder depression or anxiety. Due to limited research surrounding these issues, exploration of the therapy process in GSH has crucial importance in developing further understanding about its qualities and how it is experienced, and in particular may highlight which aspects contribute to a reduction in distress. The current study therefore aimed to explore patients' experience

of GSH for mild to moderate depression or anxiety by examining: expectations of GSH, *how* it was experienced and any change that may have occurred.

Patients in therapy are involved in complex processes where information and meanings are negotiated, not simply exchanged (Elliott & Shapiro, 1988). Qualitative methodology captures mean-making in context (Willig, 2001) and therefore enables detailed exploration of the subjective processes through which patients make sense of their experience. Consequently, Interpretative Phenomenological Analysis (IPA; Smith, 1995) was chosen to analyse the data as it aims to allow the researcher to gain an 'insider's perspective' of the phenomenon under investigation (Smith, 1996). It is an inductive approach which focuses on the individual being the 'expert' of their own experience, however, the influence that the researcher can have on the process is also acknowledged. Within this study, the author acknowledges that she would bring assumptions to the analysis. Such assumptions were formed by previous experience of working in a GSH clinic, whereby curiosity grew regarding the motivational aspects towards intervention for depression and anxiety. Furthermore, the author acknowledges that she engages with a 'critical realist' stance, which admits a natural subjectivity in the production of knowledge. Consequently, IPA is interpretative because the researcher acknowledges that the process and end product of research inevitably represents a co-construction between the researcher and research material (Smith, Jarman, & Osborn, 1999). Furthermore, IPA has not been used to understand GSH before and therefore has the unique opportunity of gaining insight into undiscovered elements of the process (see 1.7 for extended rationale). This method is therefore different to standard thematic analysis as it is a more structured approach embedded within phenomenological epistemology (Braun & Clarke, 2006).

Method (See 2.1 for overview of research design)

Participants

This data set consists of transcribed semi-structured interviews with seven participants (five women and two men) who attended GSH sessions for either mild depression or anxiety. Pseudonyms have been used and details have been changed to preserve anonymity and promote confidentiality. Their ages ranged from 23 (Ellie) to 61 (George) years and each described his or her ethnic background as White-British. Please refer to Table 1. for other demographic characteristics of the participants.

Table 1

Demographic information of participants

Participant	Age (Years)	Presenting Problem	Marital Status	Employment Status	Number of GSH sessions	Number of workbooks completed	Time elapsed since completion
Adam	45	Anxiety	Married	Employed	11	9	1 day
Jane	39	Anxiety	Married	Employed	6	6	1 week
George	61	Anxiety	Married	Employed	5	5	1 week
Rosie	32	Depression	Married	Employed	4	4	3 weeks
Margaret	46	Depression	Married	Unemployed	7	9	1 day
Emma	37	Depression	Married	Employed	7	7	1 week
Ellie	23	Anxiety	Single	Student	5	7	1 day

Recruitment

Participants were recruited using purposeful sampling from a Primary Care Service located in a rural county within the Midlands, which operates within a stepped-care model for people with depression and/or anxiety (see extended paper 2.2 for further information about the context of the service). Participants were identified from those who had been referred to the GSH clinic if the standard screening assessment showed symptoms of mild to moderate depression or anxiety, with low level risk. The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) was utilised to assess level of depression (cut-off score of five for mild symptoms and 10 for moderate

symptoms). The Generalised Anxiety Disorder-7 scale (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) was utilised to assess level of anxiety (cut-off score of five for mild symptoms and 10 for moderate symptoms). Participants were then offered GSH with a graduate mental health worker (GMHW). Participants attended clinic for a number of sessions, which was dependent on the workbooks they wanted to complete (These were from 'Overcoming Depression' or 'Overcoming Anxiety' manuals; Williams, 2001, 2003 – see extended paper 2.3 for further information about the manuals). Once completed, GMHWs provided participants with information about the study with a reply slip to be sent directly to the researcher. Participants who were on the waiting list for psychological therapy and/or had received previous intervention from a mental health/psychology service were excluded from the study (see extended paper 2.4 for further information about recruitment and inclusion/exclusion criteria). Twenty-one patients were initially approached about the study and seven patients returned the reply slip and were included.

Data Collection

The researcher conducted and audio-recorded seven semi-structured interviews, ranging in duration between 26 and 62 minutes. Interviews took place either in the participant's home or an NHS clinic, according to their preference. The interview procedure followed that described by Smith (1995) and followed an interview schedule that specified the topics to be discussed, i.e., the participants' 'expectation' and 'experience' of GSH and any 'changes' that may have occurred as a result of GSH (see extended paper 2.5 for further information regarding the use of an interview and construction of the schedule). The aim was to facilitate participants telling their own experience of GSH. The verbatim transcripts of the interview served as the raw data to

be analysed using interpretative phenomenological analysis (IPA) as described below (Smith, 1995).

Ethics

Ethical approval for this study was granted by the relevant Local NHS Research Ethics Committees (see extended paper 2.6 for further ethical considerations).

Analysis

An idiographic case-study approach to IPA was employed as recommended for sample sizes of 15 or under (Smith *et al*., 1999) (see extended paper 2.7 for discussion about the use of IPA and its theoretical underpinnings). All interviews were audio-recorded and then transcribed with wide margins used for coding. Throughout analysis attention was paid to the dual process that occurs within IPA, i.e., the 'double hermeneutic', whereby 'the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2008, p. 53). Interpretation is therefore required to take into account the researcher's personal standpoint. The process of analysis followed four steps:

1. Initially, the researcher familiarised herself with each script separately. Comments about the meaning of particular sections were added into the left hand margin.
2. Transcripts were read again. The fundamental meaning of phrases and descriptions used within the transcripts were questioned. Developing themes were identified and organised in the right hand margin.

3. Attention was then focused on the themes themselves and common links between the themes were identified. Changes to themes were continuously compared with transcripts to ensure analysis remained rooted in data.
4. A summary table was produced containing the final superordinate and subordinate themes alongside supporting statements/quotations.

Consistent with the phenomenological approach these themes are then considered in relation to the existing literature in the Discussion section (see extended paper 2.8 for further information about data analysis).

Validation Methods

As IPA relies on the researcher's interpretation of data, it was important to ensure that interpretations were as trustworthy as possible. Standards for the conduct of good qualitative research, including considerations of validation (e.g., Yardley, 2000) were adhered to in this study. Validation methods included: completion of a research diary to create an audit trail (ensuring transparency of analytic process), completion of a reflexive diary to document the influence of the researcher on the findings, and utilisation of supervision to provide an ongoing critique of the work. Smith (1996) also suggests several criteria to assess the internal validity and reliability of qualitative research. These include internal coherence and presentation of evidence. Internal coherence refers to the need to concentrate on whether the argument presented in the research is internally consistent and justified by the data, and verbatim evidence should be presented in the paper to allow the reader to interrogate the interpretation (Smith, 1996) (see extended paper 2.9 for further discussion about quality assurance measures).

Results

This section presents four superordinate themes that emerged from the analysis. These were 'participants' intention to feel better', 'development of understanding and awareness', 'change: from dependency to independence' and 'relating to others'. Subordinate themes were identified which elaborated the superordinate themes and reflected commonalities in the accounts (Smith, 1996) (see extended paper 3.1 for an audit trail).

In the present study, the three themes deemed to be of greatest clinical interest are presented in full ('participants' intention to feel better', 'development of understanding and awareness', and 'change: from dependency to independence'). The remaining theme, 'relating to others' is summarised as the focus of research is on the therapeutic process of GSH and not external concepts to the GSH experience (see extended paper 3.2 for a full analysis). The first theme, 'participants' intention to feel better' sets the scene for the following two themes as it articulates participants' attempts to improve well-being, and shows how development of independence and application of new skills facilitate future management of difficulties.

In the following sections, when quotations are cited, empty brackets ( ) indicate where material has been omitted; information in square brackets [ ] has been added to clarify material and ellipsis points (…) indicate a pause in the participant's speech.

Participants' intention to feel better

All participants accessed help via their GP who discussed various options of treatment such as medication, counselling or GSH. After referral they received a leaflet offering details about GSH, e.g., approximate number of sessions and having to complete 'homework'. However, participants described themselves as 'not knowing what to expect' and were unaware of what GSH would contain. Despite limited

knowledge about GSH and unclear expectations, all participants described strong intentions to try any available means to improve how they were feeling. They believed that GSH was an opportunity in which they could change the negative feelings that they were experiencing (see extended paper 3.3 for a reflexive account of this theme).

> I'd just got to the stage where I was open to any sort of help that could improve the way that I felt (…) I was driven to strive, to get myself out of the cycle (Adam).

> But not just to have to deal with the immediate situation, but for the future, as a resource that I could reuse in the future (…) was a situation where I felt that I needed it (Margaret).

Three other participants (Jane, George and Emma) also wanted to learn and understand about what caused their difficulties, explaining their belief that it would help them manage their mental health in the future.

> I think really it's just to, kind of, learn what my personal triggers are, you know, what triggered the feelings of anxiety ( ) get a better understanding of what it was that erm (…) triggered that for me so that I could recognise it in the future (Jane).

> I needed to understand (…) or go through a process to understand me better (…) and that was what I was hoping for (Emma).

George's account in particular suggested he had a strong determination to discover the initial cause [of his panic attacks] despite being advised during his initial assessment to focus on the 'here and now' instead of dwelling on the past, as suggested by cognitive-behavioural theory (Rachman, 1997).

> I also wanted to try and find out what had triggered it and where it had started and I think in the initial assessment that I had [with the CPN] (…) I think the guy was trying to push me away or steer me away ( ) 'don't try and look back and see what triggered it, try and look towards the future' (…) then I still had it within the back of my mind that I really wanted to try and find out what was the initial cause.

The belief that George had about finding out the initial cause also affected the way that he felt about the outcome of GSH.

> It was important to me to find out what had caused it [anxiety and panic attacks] because I believe that if I hadn't found out the cause of it (…) then what was to stop this cause happening next week?

Participants also recognised how important motivation would be to others if GSH is to be accessed. In particular, if people are not curious about available help, they might be unaware of available treatments as only limited information is offered. Another participant, Adam, described how he had to request GSH as it was only briefly mentioned as an available treatment. This captures the participants' experience that motivation was a necessity for people to, first, accept and benefit from GSH, and second, motivate themselves to complete the activities and exercises. Adam said:

Others would need more encouragement to use it.

You've got to be willing to apply that learning, so I think somebody can give 100% but still not get the benefit if they're not prepared to take that learning and apply it to everyday situations and relationships.

Development of Understanding and Awareness

This theme refers to the use participants made of the knowledge and reassurance provided in GSH. All participants developed understanding and awareness about their thoughts and feelings and acknowledged that GSH was about management, not cure. Further, they described understanding that their difficulties were 'normal', whilst also moving from a position of being 'stuck' with their difficulties to a more active and positive position, where they felt they could change.

I think it's being able to recognise it's normal to feel that way and just do something about it rather than just let that feeling (…) that negative feeling grow (Jane).

It was a big learning curve in that respect but other parts of the course just reiterated to me that I actually did think in a logical process ( ) to understand that the feelings that I was feeling was absolutely normal (Emma).

Comparing current self with previous self

Participants also offered descriptions about what they thought and felt prior to and after GSH. In other words, each described him- or herself as needing to do things

differently than in the past and related this activity to managing his or her own mental health. For example, Rosie described how she would normally behave as a 'people pleaser' but acknowledged that this contributed to her negative feelings.

> I always thought I tried to be nice to people and tried to be kind to people and I always thought that was a good way to be and then it took this whole episode [of depression] to think (…) you're too much the other way and you need to have a balance.

Emma too referred to how she used to behave and how she now copes.

> I'd always struggled to be assertive with other people around me, sort of a passive-aggressive approach to things, which has made me really unhappy so it helped me to understand that tackling things head on and saying exactly how you feel, without being offensive obviously, works.

Management rather than cure

This subordinate theme reflects that although no participant claimed to be 'cured', changes had taken place that participants attributed to GSH. For example, Adam and Margaret described how they still occasionally experience emotional disturbance or think about situations in ways that require self-help.

> There are certainly times now where I can feel some of the thoughts and issues building up again but having that framework to go back on I think has definitely helped (Adam).

> You look at the workbook when you're ill, and when you're better you don't think that you need them, and you just slowly start to let some of your old thought patterns come back in again, and it's about being aware and thinking, oops (…) there we go again (Margaret).

Participants described an understanding that the mental health problem they had experienced was cyclical and that continuation with self-help was required to maintain their improved mental health. They therefore view their experience not in terms of cure, but in terms of ongoing management.

> I hope that I carry on the way that I am (…) that I just keep building on the skills and keep practicing (…) and that if I do have off days, that I can identify what it is that's making me feel off (…) is there something that I can do (Rosie).

> If you don't carry on with the thoughts that are in the booklet you can slip into your old ways. It's about practicing, remembering to take stock without carrying on and carrying on, and thinking, what am I letting slip here, I'm not feeling as well as I should (…) being aware (Margaret).

Change: From dependency to independence

This theme explores an experience of change whereby participants initially required the reassurance and validation of professional support, then developed independence and confidence in utilising the self-help material themselves. However, whilst participants gave value to the support that they received from the GMHW, they each offered different accounts as to why.

Wanting Reassurance

Adam, Jane and Margaret described that it was useful and positive to talk to an independent, non-judgmental person about their experience and also appreciated having the reassurance and clarification that the support provided in guiding them through the workbooks.

> I think it was very useful just to have somebody who was completely independent from a sort of trained background to say you probably are doing the right sort of things, and reconfirming the sort of exercises and the actions that you should be continuing to use (Adam).

> I felt as if the conversations I had just validated that this is what I need to focus on, she listened to where I was and the self-analysis that I'd done and that was validated by her (Jane).

Someone to spur you on

For five of the participants (Adam, George, Rosie, Margaret, Emma) having support was influential in completing the workbooks, knowing that somebody was going to ask how they were. For example, Emma described how she was initially going to complete computer-based self-help but after further reflection, changed to GSH, stating that, 'I felt that it would be too isolating and I realised that was not what I needed'.

> You're more likely to work your way through the booklets because you know that you're going to see somebody who'll ask you how you got on or ask about how you feel.

> Knowing that I was seeing somebody who might ask me a question and ask how I was (…) it spurred me on.

This dependency upon support in the initial stages was clarified by Jane and Rosie's accounts of how they would have felt without the guidance.

> I think because it was complimented by having access to Naomi [GMHW], I felt as if I was getting the right materials. So if it had been kind of (…) 'here's a website and pull off what you need' (…) well what you think you might need and what you actually need might not be the same thing (Jane).

> I don't think it would work if you didn't have somebody to go back to each week…because I was like, give me the workbooks and wanting to tackle everything at once (Rosie).

Feeling independent

Whilst validation of feelings was initially important, participants described a transition to a position of confidence in their own ability to use specific therapeutic skills or change past behavioural patterns associated with being depressed or anxious.

> It gives you that independence as much as anything else, which helped (Adam).

> What the support worker has been able to do in the conversations is reassure me that my intuition or my instinct is usually right…so that I can trust myself to think…yeah, that is what I'm feeling and that's how I need to deal with it (Jane).

Through their descriptions of using new techniques to manage their difficulties, participants highlighted the impact that the process of GSH has had on their confidence in helping themselves. This contrasts with their initial dependency at the beginning stages of GSH.

This was not a universal experience however; Rosie was more hesitant and expressed uncertainty about ending the GSH sessions. She described how she would attempt to identify and manage those difficulties.

> There's been the odd occasion where I've thought that it would be good to just chat that through but on the other hand it's, sort of, not enough to justify a session (…) but then I can usually, if I give myself time out, I can work it out. So it's about having that time.

Relating to others

Participants had different views about involving family and friends in their experience. Although some participants described them as an important, supportive factor in their experience (Adam and Jane), others described their involvement as difficult because they thought it would exacerbate feelings of guilt (Margaret, Emma, Ellie) and felt that professional support was more essential in terms of feeling understood (George). One participant actually felt supported by family and friends but described how changes that occurred as a result of GSH were difficult for her husband to comprehend (Rosie). This therefore illustrates a discrepancy between wanting to feel understood and supported by others, and not wanting to feel like a burden.

Discussion

In this study, expectations that participants had about GSH were often unclear and not based on any understanding about what it involved, but reflected hope and a strong motivation to feel 'better'. Whilst previous research has focused on the role of expectancies in determining patient attitudes about accessing GSH (Macdonald *et al.,* 2007), this sample of participants referred to 'hopes' of what GSH would provide, which is a construct entirely independent of expectation (Olsen, Roese, & Zanna, 1996). The participants' experiences may therefore be interpreted in relation to Self-Determination Theory (SDT; Ryan & Deci, 2000) (see 4.1.1 for further consideration of SDT). According to SDT, when individuals are more autonomously engaged, they are more likely to integrate learning and behaviour change, resulting in more positive outcomes. Therefore, the more autonomous individuals are in their motivation for therapy, the more important they believe therapy to be (Pelletier, Tuson, & Haddad, 1997).

Within the current study, narratives provided by participants indicate they entered treatment for autonomous reasons in order to search for change, expand and use their own capabilities, and discover and learn (Ryan & Deci, 2008). Without such autonomy and motivation, GSH may not have been accessed and suggests there are other factors to consider regarding patient decision-making and access to psychological therapies. Additionally, participants reflected on positive outcomes of GSH and how they overcame particular challenges. Evidence suggests that because autonomy is related to goal progress (Koestner, Lekes, Powers, & Chicoine, 2002) and sustained effort (Sheldon & Houser-Marko, 2001), patients with more autonomous goals may be better able to confront and overcome difficulties and barriers to change, leading to more positive outcomes (Michalek, Klappheck, & Kosfelder, 2004).

Participants proceeded to describe their experience by comparing past and present selves, illustrating a development of understanding and awareness. Awareness refers to a state in which people experience a relaxed interest, and at a particular point in time, feel free from painful experiences that have been blocked (Deci & Ryan, 1985). Further to this however, the increased knowledge present in participants' descriptions illustrated change via assimilation, whereby they had 'taken in' a new experience. They had integrated it, explained it and incorporated it into a system of associations (Stiles *et al*., 1990), which might account for the shift in experience that participants reported from 'understanding and awareness' to engaging with the self-help techniques.

Previous psychological therapy research has highlighted the importance of the therapeutic alliance between patient and therapist in facilitating patient change (e.g., Martin, Garske, & Davis, 2000) (see 4.1.2 for further consideration of therapeutic alliance). Despite reduced contact with the GMHW, participants highlighted the importance of having such support in the early stages, as this offered reassurance and maintained attention on their difficulties. Furthermore, working collaboratively with the GMHW was regarded by the participants as an integral component of the therapeutic alliance, which has been proposed as a strong indicator of outcome (Martin *et al*., 2000). However, an important element within the theme of 'change' was the development of participants' self-belief to implement self-help strategies and overcome their difficulties. The findings suggest that whilst there was an initial reliance on the GMHW, participants were able to develop self-reliance once they had acquired an understanding of their difficulties. Subsequently, participants experienced an increase in self-efficacy and described feeling capable of managing their depressed and anxious symptoms in the future (see 4.1.3 for further consideration of change and self-efficacy).

The themes which emerged in this study support previous research findings (e.g., Rogers *et al*., 2004) and highlight the need to attend to the therapeutic processes

that patients experience through GSH, as they have to deal with a desire for self-reliance and the need for therapist support (Glasman, Finlay, & Brock, 2004). The data would indicate that experiences of change in GSH rely on aspects of the therapeutic alliance, such as the positive and encouraging nature of the patient–therapist relationship. However, it is important to acknowledge, as indicated within these findings, that GSH relies on the motivation of patients to achieve positive effects.

An IPA study does not aim to produce findings that can be generalised to a wider population and cannot conclude that all patients will experience GSH in such a positive way. However, these findings might have implications for how best to implement efficient GSH. Given that all participants commented they had received insufficient information about GSH, further information could help in explaining the personal responsibility for rebuilding capacity for self-reliance, and highlight the philosophy of change underpinning GSH. Previous research has shown that delivering effective self-help in primary care can be complex, and influenced by the attitudes of both professionals and patients (Jones, Pill, & Adams, 2000; Khan *et al.,* 2007; Macdonald *et al.,* 2007; Rogers *et al.,* 2004). However, this study contributes further understanding by highlighting the additional importance of autonomy and motivation in accessing and participating in GSH. Greater emphasis on information prior to referral might also encourage the motivational change needed in other patients to maximise the effectiveness of self-help strategies. Additionally, fresh motivation may also be required to maintain management of their mental health, which could be achieved in two ways. First, therapists could discuss end-of-treatment plans in the context of how patients can draw on their resources and skills to maintain their improved mood. Second, patients could attend 'booster' sessions following a period of time after discharge if they require a reminder of their skills (see 4.2 for further clinical implications).

The method used in this study has strengths in focusing on patients who were referred to and experienced GSH. Asking about the different stages of GSH (e.g., expectations, experience and change) allowed an analysis that could reflect and interpret the processes which occurred prior to as well as those actually involved in the intervention itself. However, there are several limitations within this study. First, the GSH service was provided by one particular PCT which, in terms of sociodemographic status, is advantaged and privileged. Participants also expressed a willingness to succeed and acknowledged that achievements occur through being proactive; hence GSH was a successful option for them. Therefore, the views expressed represent those of privileged participants who attended the clinic and received a course of treatment and did not include people from lower social classes. Second, all participants expressed a highly positive experience, indicating a sampling bias, and therefore does not take into account the experiences of people who may have completed GSH but did not have such a positive experience. Third, the study relied on retrospective interviews and would have benefited from completion of two interviews (pre- and post-GSH) to ascertain initial expectations. Consequently, this can only be a partial description of the full range of participants' expectations and experiences and further studies in other settings are required. It is also important to be aware of the researcher's influence on the data. As mentioned previously, there was an initial curiosity about patients' motivation to complete treatment for depression and anxiety. Previous experience indicated that, similar to other research findings, uptake rates of GSH were low and there was a thirst for understanding why? What could be done? A reflexive diary and supervision therefore ensured that interpretation focused on the research question (see 4.3 for strengths and limitations of IPA methodology). Future research can help address several key areas. Interviews could be held with patients who decline GSH to ascertain explicit reasons for failure to access GSH. Taking into account that factors other than attitudes

may affect accessibility, it will be beneficial to investigate the relationship between self-determined motivation and uptake levels of GSH. And finally, whilst this study has emphasised and supported other research findings about the active components of change in GSH, it might be useful to explore which aspects of GSH patients themselves attribute to perceived change (see 4.4 for future research considerations).

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EXTENDED PAPER

This paper offers further description of the study and should be read only in conjunction with the research paper. The first section of the paper will aim to provide additional background information such as, definitions about anxiety and depression, and descriptions of services such as, Improving Access to Psychological Services (IAPT) and the 'stepped-care' model. Information about these services are included to provide some context in which guided self-help is offered for people with mild to moderate depression and/or anxiety. Furthermore, consideration of theoretical and empirical literature will also be included paying particular attention to factors such as therapeutic change and the importance of the therapeutic alliance, and a review of empirical findings of guided self-help. In keeping with the inductive principles of Interpretative Phenomenological Analysis (IPA), discussion of theory will be kept to a minimum until the discussion section, where relevant theories and their relationship to the findings are outlined in more depth. The methodological approach of IPA will be discussed in more detail, including its theoretical underpinnings and the use of quality assurance measures. The second section of the paper will present additional analysis of results, alongside an audit trail describing the process of analysis. The final section of the paper will comprise a more detailed appraisal of the study's strengths and weaknesses and a critical reflective component will also be included to discuss particular issues raised by the research.

Section One: Background

1.1 Definition of depression

Depression is known as a mood disturbance resulting from an interaction of many factors including biological, historical, environmental and psychosocial variables (Fennell, 1989). When people are clinically depressed, they feel sad and are often tearful, are troubled by guilt, become more irritable than usual, and find it difficult to enjoy normal activities. People become preoccupied with how bad they feel and the problems that they face. Depression is therefore

characterised by generally pessimistic and self-critical cognitions with increased feelings of negative affect (Beck *et al*., 2001). According to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition-Text Review (DSM-IV-TR; APA, 2000), depression is defined as a depressed mood or a loss of pleasure in all, or almost all, activities, and is accompanied by at least five associated symptoms such as, appetite disturbance, change in weight, sleep disturbance, agitation, decreased energy, feelings of worthlessness and difficulty thinking. The International Statistical Classification of Diseases and Related Health Problems-Tenth Revision (ICD-10; World Health Organisation, 1992) uses an agreed list of 10 depressive symptoms (e.g., low mood, fatigue, anhedonia) and divides the common form of depression into four groups: not depressed (fewer than four symptoms), mild (four symptoms), moderately depressed (five to six symptoms), and severe (seven symptoms or more, with or without psychotic symptoms). These symptoms must be present for at least two weeks.

1.2 Definition of anxiety

Anxiety can be distinguished in two ways. For the first, the core problem is recurrent panic attacks which can occur unexpectedly and in almost any situation. These attacks consist of a sudden and intense apprehension, and involve a range of distressing physical sensations such as, breathlessness, palpitations, chest pain, choking, dizziness, tingling in the hands and feet, sweating, and feelings of unreality (Clark, 1989). In the second anxiety state, the core problem is excessive anxiety about various life circumstances (generalised anxiety) and is not related to worry about panic attacks. Again, a range of physical symptoms may be associated with this anxiety such as, breathlessness, palpitations, sweating, dry mouth, nausea, diarrhoea, flushes or chills, frequent urination, feeling on edge, insomnia and irritability (Clark, 1989). Beck (1976) argued that in anxiety states, individuals systematically overestimate the danger in a given situation. According to the diagnostic criteria of the DSM-IV-TR (APA, 2000), anxiety is defined as an excessive anxiety or worry about various events and situations, with a significant difficulty in controlling the anxiety and worry. It needs to have been present for most days over a six month period and include three or more of the following problems:

feeling tense, concentration difficulties, irritability, significant tension in muscles and sleeping difficulties. The ICD-10 (World Health Organisation, 1992) states that the sufferer must have primary symptoms of anxiety most days for at least several weeks at a time, and usually for several months. These symptoms should usually involve elements of: apprehension (worries about future misfortunes, feeling tense, difficulty in concentrating, etc.), motor tension (restless fidgeting, tension headaches, trembling, inability to relax), and autonomic over activity (lightheadedness, sweating, tachycardia or tachypnoea, epigastric discomfort, dizziness, dry mouth, etc.).

1.3 Improving Access to Psychological Therapies (IAPT)

Over the past several years research has been conducted in order to improve the care of depression and anxiety. Whilst historically drug therapy has been the favoured method of treatment for these disorders, as demonstrated by prescribing patterns and over-reliance on particular medications (Tiller, 1994; Tylee & Donoghue, 1996), the clinical effectiveness of psychological therapy, in particular, cognitive-behavioural therapy (CBT), has become more accepted (Department of Health, 2001). Patients are often reluctant to take medication for depression and anxiety (Gask, Rogers, Oliver, May, & Roland, 2003), and some GPs have been criticised for not spending time listening to patients (Lown, 1996) or having the skills and enthusiasm for mental health work.

Improving access to psychological therapies has now been regarded by the UK government as a priority for three reasons. First, the effectiveness of psychological therapies has been demonstrated through the publication of National Institute for Health and Clinical Excellence (NICE) guidelines. Second, because patients report wanting greater access to talking therapies (Department of Health, 2004, 2006; Rankin, 2005; Sainsbury Centre for Mental Health, 2006). Third, the socioeconomic benefits on individuals' wellbeing and the nation's wealth in the form of its impacts on disability and welfare benefits, as argued by Lord Richard Layard (Layard, Clark, Knapp, & Mayraz, 2007; Layard, 2006). The IAPT implementation plan involves expansion of the specialist workforce, a range of professionals trained to deliver both low and high intensity therapy with its focus on CBT, although the focus will broaden as the deficit is addressed. One of the most significant aspects of access to

psychological therapies is how resources are coordinated within models of service delivery, a major feature of which is the 'stepped-care model' (Turpin, Richards, Hope, & Duffy, 2008).

1.4 Stepped-Care Model

Low cost interventions as part of stepped mental health care models may provide a means to satisfy the mental health consumer (Scogin, Hanson, & Welsh, 2003). The stepped-care model of healthcare delivery provides a way to meet the demands for those requiring services whilst maximising treatment resources. In stepped-care people receive the most brief and least complicated levels of intervention that is appropriate to their needs early on before moving up the steps to more complicated therapies, only when lower steps fail or are inappropriate. This means that the results of treatments are monitored and changes are made if the current treatment is not achieving a significant health gain (Bower & Gilbody, 2005). Although these features of stepped-care may seem to resemble the way in which many clinicians already operate (King *et al*., 2002), stepped-care standardises systems and procedures with a specific aim of improving efficiency (Katon *et al*., 1997; Scogin *et al*., 2003).

Stepped-care therefore requires treatments of differing intensity and this requirement is satisfied in psychological therapies where a number of less intensive treatments have been developed, for example, brief therapies (Scott *et al*., 1997), group treatments (Dowrick *et al*., 2000), and self-help approaches such as, bibliotherapy (Cujipers, 1997) and computerised treatments (Proudfoot *et al*., 2004). Evidence suggests that guided self-help may be a realistic way of delivering a brief cognitive-behavioural based therapy in the early stages of someone's mental health care (Cuijpers, 1997; Williams, 2001; Elkers & Lovell, 2002; Newman, Erickson, Przeworski, & Dzus, 2003) increasing the capacity for psychological therapies.

1.5 Theoretical Literature

This section outlines the theoretical literature relating to CBT theory as GSH is based on cognitive-behavioural principles. It will pay particular attention to the relevance of therapeutic change, therapeutic alliance and the effectiveness of CBT.

1.5.1 Cognitive Theory

CBT arose from the integration of cognitive theory (Beck, 1964, 1976) with behavioural perspectives, and proposes that *experience* leads people to form *assumptions* about themselves and the world, which are consequently used to organise perception, as well as govern and evaluate behaviour. Therefore, the ability to make sense of individual experiences is beneficial to normal functioning. However, some assumptions are rigid and resistant to change, and become 'dysfunctional' (Fennell, 1989). These assumptions affect what people need in order to be happy, and what they must do in order to believe that they are worthwhile. Problems develop when *critical incidents* arise and connect with the person's individual set of beliefs, generating *negative automatic thoughts* (NAT's). These NAT's are appraisals of events which impact on affective state and behaviour (Wells, 1997) and increase unpleasant emotions. These can lead to other symptoms, which effect behaviour, motivation, emotions, cognitions and the physical self. As these develop, NAT's become more frequent and intensify, and it becomes more difficult to think rationally, forming a vicious circle (Wells, 1997).

Overall, cognitive theory states that emotional difficulties are caused and maintained by the interpretation of an event, not the event itself (Beck, 1964). In depression the interpretations which are believed to be important are associated with perceived loss, such as relationship, status, or efficacy. In anxiety, the important interpretations or thoughts are associated with perceived physical or psychosocial danger (Clark, 1989). Therefore, the challenge in everyday life is not having to deal with the cause of the problem but having to cope with the thoughts and emotions associated with it (Kadam, Croft, McLeod, & Hutchinson, 2001). Hence, the focus of treatment is primarily upon the here-and-now rather than the past and includes a range of behavioural (e.g., goal setting, action planning, monitoring progress, self-reward, relapse prevention) and cognitive (e.g., evaluating how current beliefs influence behaviour) techniques for producing change (Conner, 2005), which can be delivered in a range of formats such as; groups, individual, computerised and workbooks. Furthermore, a key assumption about CBT's effectiveness is its ability to delay or prevent relapse by enabling patients to develop such techniques, which they can continue to use on completion of therapy (Beck, 1995).

1.5.2 Therapeutic Change

Beck and his associates suggest that active modification of thoughts can lead to change and are quite specific about the hypothesised active components of CBT, stating that interventions aimed at cognitive structures or core schemas are the active change mechanisms (Beck, Rush, Shaw, & Emery, 1979), which is also supported by other research (Fennell & Teasdale, 1982; Tang & DeRubeis, 1999; Feeley, DeRubeis, & Gelfand, 1999). Beck and colleagues (1979) theorise that to maximise the efficacy of CBT, active modification of thoughts and schemas (generalised representations of self and others) is necessary.

Despite this conceptual clarity, Jacobson and colleagues (1996) stated that treatment is so multifaceted that a number of alternative accounts for its efficacy are possible. They labelled two primary competing hypotheses: the 'activation hypothesis' and the 'coping skills' hypothesis. According to the activation hypothesis, CBT effects change through the activation of clients, by instigating them to become active again and to put themselves in contact with available sources of reinforcement. It has been noted that much of the change during CBT occurs within the first few weeks (Rush, Beck, Kovacs, & Hollon, 1977), when instigations toward activation play a prominent role in the treatment. Previous studies that found CBT more effective than behavioral activation (e.g., Shaw, 1977) may not have used activation strategies that work as well as those used in CBT. According to the coping skills hypothesis, clients learn to cope with depressing events and depressogenic thinking during CBT and it is this new set of skills that, along with activation, accounts for the alleviation of depressive behavior (Jacobson *et al*., 1996). In other words, it is not that core cognitive structures are altered, but that people learn effective coping strategies for dealing with life stress.

Prior to these hypotheses, Hollon, Evans, and DeRubeis (1988) also proposed three possible change mechanisms. Firstly, that CBT modifies depressogenic beliefs and/or cognitive processes involved in the maintenance of core negative cognitive schemata (the 'accommodation' model). Secondly, that CBT deactivates rather than changes depressogenic schemata and activates pre-existing benign ones (the 'activation-deactivation' model). And thirdly, that CBT leads clients to acquire new cognitive skills to curtail negative

thinking or pre-empt it rather than modifying or deactivating negative thinking (the 'compensatory skills' model). Meichenbaum (1979) suggested that changes in cognitive process (e.g., distraction techniques) as well as cognitive content were active ingredients in CBT change mechanisms.

Teasdale (2000) argued CBT delayed relapse by breaking the previously strong connection between mood disturbance and the client elaborating negative self-referrent cognitions from it. However, such cognitive accounts have been challenged. Jacobson and Gortner (2000) argued that early acceptance of the treatment rationale allowed a client to change his or her behaviour in such a way that enabled him or her to come into contact with positive reinforcers in the environment. Similarly, it has been theorised that the presentation of a coherent treatment rationale might increase a client's feelings of hope leading to recovery (Addis & Jacobson, 2000). Shaw and Segal (1999) proposed CBT was effective because of the specificity of its approach and the self-help ethic it promoted through within-therapy homework. Bordin (1979) has also pressed for a strong therapeutic alliance being the active mechanism of change in talking therapies, including CBT.

Additionally, various stages of change in therapy have been proposed by Stiles *et al.* (1990) highlighting that different aspects of therapy might be relevant to different stages of change and illustrates the importance of asking about patients' experiences. The assimilation of problematic experiences is a meta-theoretical approach to change in psychotherapy. It encompasses a wide range of phenomena, including cognitive and affective features of client behavior. The model is integrative, drawing concepts from psychodynamic, experiential, cognitive-behavioral, and personal construct theories, as well as from cognitive and developmental psychology (Stiles *et al.,* 1990).

The model's principal concepts include: schema, problematic experience, and the complementary processes of assimilation and accommodation. A schema is a familiar pattern of ideas, a way of thinking to which new experiences can become assimilated. A problematic experience is a perception, intention, impulse, attitude, wish, fantasy, or idea that causes psychological discomfort when brought to awareness or put into action and are not adequately contained by the available schemata. Consequently, people cannot speak or think clearly about them. They cause the person psychological pain, or they

lead to behavior that impairs relationships with others (Stiles *et al.,* 1990). In assimilating a new experience, a schema integrates it, explains it, and incorporates it into a system of associations. After being assimilated, the formerly problematic experience is part of the schema; therefore, a schema comes to consist partly of the personal insights achieved during therapy. The complementary process, accommodation, takes place simultaneously with assimilation. Accommodation refers to changes both within a schema and within an experience that are required for the two to become associated. Therefore, as a problematic experience becomes assimilated, both the experience and the schema must change to accommodate each other. Assimilation and accommodation occur simultaneously and inseparably during psychotherapy (Stiles *et al.,* 1990).

According to the model, assimilation of an experience to a schema requires bringing their common elements to awareness, so that they can become interconnected. Unlike new experiences assimilated in ordinary learning, the problematic experiences assimilated in psychotherapy involve a discrepancy from or an inability to be contained by the patient's current schemata. The associated psychological pain leads the patient to organise his or her life and thinking to avoid these experiences. Consequently, the therapeutic relationship and context must work against resistance to hold and focus the patient's attention (Stiles *et al.,* 1990). Clarke, Rees, and Hardy (2005) found that their participants' experiences of CBT fitted with the assimilation model. Furthermore, Bennett-Levy (2003) found that peoples' experiences of change are felt in a different way and highlights the importance of seeking patients' experiences, shedding light on what occurs for them and their understanding of the aspects of guided self-help that related to these experiences.

Social Cognitive Theory (Bandura, 1997) explains human behaviour in terms of a triadic, dynamic and reciprocal model in which behaviour, personal factors, and environmental influences interact. It addresses both the psychological dynamics underlying behaviour and their methods for promoting behaviour change. It is a very complex theory and includes many key constructs, of which, self-efficacy is one of them and refers to one's confidence in the ability to take action and persist in action. It is seen by Bandura (1986) as

perhaps the single most important factor in promoting changes in behaviour. Measures of self-efficacy and some of the other key concepts from social-cognitive theory have also been identified as key determinants of movement through the stages of change (Oldenburg, Glanz, & French, 1999). Self-efficacy expectations have been found repeatedly to be important determinants of: the choice of activities in which people engage, how much energy they will expend on such activities, and the degree of persistence they demonstrate in the face of failure and/or adversity. In general, higher levels of self-efficacy for a given activity are associated with higher participation in that activity. However, depression and anxiety may impair both self-efficacy beliefs, and the ability to engage in those behaviours that might increase self-efficacy (Maciejewski, Prigerson, & Mazure, 2000).

Consequently, motivation to engage in treatment may also be decreased. Self-Determination Theory (SDT; Deci & Ryan, 1985) is one theory that explains why individuals may or may not pursue psychotherapy (Ryan & Deci, 2008). It is based on the assumption that all individuals have an innate and constructive tendency to develop an ever more integrated sense of self. This desire to have an integrated sense of self can be supported or thwarted by social-contextual factors. The model suggests that all individuals have three innate basic psychological needs: the need for competence, which is an individual's desire to interact effectively with the environment, autonomy, which reflects an individual's desire to engage in the activity they choose and to be the origin of one's own behaviour, and relatedness, which involves feeling connected or related to a given social setting (Deci & Ryan, 1985). Social environments that allow satisfaction of the three basic needs are believed to support an integrated sense of self and healthy functioning, whereas factors associated with need thwarting or conflict are thought to be antagonistic (Deci & Ryan, 1985). Psychotherapy depends upon the ongoing willingness of patients to recognise and work on specific and potentially multiple problem areas in their life, the goals of which may change. Consequently, the issue of motivation and creating lasting change are central to all psychotherapies (Ryan & Deci, 2008).

1.5.3 Therapeutic Alliance

Another aspect of CBT is that the therapeutic relationship has been found to relate to change. Beck (1976) described the therapeutic relationship as the 'context' on which specific CBT techniques are applied. This is echoed by Goldfried (2004) who described the relationship as 'like the anesthesia that allows for a surgical procedure to be performed' (p. 98). This is in sharp contrast to other schools of psychotherapy that view the relationship as central to a patient's recovery. However, researchers have suggested that even in cognitive therapy, there may be an association between the therapy relationship and the outcome, independent of the relationship between outcome and specific CBT techniques (Waddington, 2002; Safran & Segal, 1996). The role of the facilitator can therefore be important to build an effective and collaborative therapeutic alliance to help patients develop their CBT skills and knowledge to cope with post-treatment emotional difficulties. Theories of relational change propose that clients who feel accurately perceived 'will be more likely to invest themselves in the treatment process' (Bohart, 2000, p. 136). Feeling well enough understood to experience emotion in therapy, clients might feel that negative feelings are acceptable, and thus be more ready to engage in therapy. This may have implications for CBT treatments with less emphasis on the therapeutic relationship (e.g., computerised CBT, bibliotherapy).

1.5.4 Effectiveness of CBT

The clinical usefulness of CBT for depression has been documented by a number of investigators. In a meta-analysis of this approach, Dobson (1989) suggested that CBT is at least as powerful and perhaps more effective than behavior therapy, pharmacotherapy, and other psychotherapies or waiting-list control conditions. Some have questioned this evidence (Hollon, Shelton, & Loosen, 1991). However, CBT has showed long-term effects that were at least as durable, if not more so than pharmacotherapy or interpersonal psychotherapy (Shea *et al*., 1992). Whilst CBT has been highlighted by guidelines as the treatment of choice for a number of disorders (Department of Health, 2001), it also has the advantage of similarity between different 'steps' (within a stepped-care model) by being based on the same theoretical model and therapeutic technique. Despite the advantages of consistency, it is

questionable whether 'stepping up' to an approach that has already failed may be counterproductive (Newman, 2000). However, a stepped-care model might involve 'stepping up' to differing treatments such as counselling or interpersonal therapy, as these may have an effect on different aspects of the person's problem (Newman, 2000).

1.6 Empirical Literature on Guided Self-Help

This section outlines the key empirical findings that have been discovered within the evidence-based research conducted on the use of guided self-help.

Guided self-help involves the delivery of cognitive-behavioural techniques facilitated through a small amount of contact with a therapist (Khan, Bower, & Rogers, 2007). Reviews and meta-analyses of self-help treatments, in contexts other than primary care, have suggested that self-help can be more effective than no care (Scogin, Bynum, Stephens, & Calhoon, 1990; Gould & Clum, 1993; Christensen & Jacobson, 1994; Marrs, 1995). However, most studies within the meta-analyses included people who experienced relatively minor problems and were recruited by the media or students, while only a few were randomised clinical trials. Therefore, these reviews and meta-analyses are insufficient to draw robust conclusions about the effectiveness of guided self-help for patient populations with clinically significant emotional disorders in non-primary care settings. Regarding primary care, a systematic review of the clinical and cost effectiveness of self-help treatments for anxiety and depressive disorders was conducted by Bower, Richards, and Lovell (2001). Originally, guided self-help was used usually after the patient had made contact with specialist professionals, which limited availability to people passing the primary care filter. It was recognised that access to effective psychological therapies in primary care was problematic because of the limited number of trained professionals. With guidelines recommending self-help treatments to improve access to psychological therapies, Bower *et al*. (2001) wanted to review the evidence concerning self-help treatments of anxiety and depression in primary care. Included in the review were randomised control trials (RCTs) and controlled before-and-after studies, and disorders involving significant anxiety and depression. Effect sizes, the difference in symptom levels after treatment between the intervention and control group, were calculated for the most

frequently used measures of anxiety and depression in each study. Eight studies were identified for the review and 18 studies of self-help in primary care were excluded because they did not meet the design, intervention or patient population criteria.

Significant outcome benefits related to self-help treatments in relation to scores on outcome measures were found. However, the mean effect size (based on means and standard deviations) of 0.41 (95% confidence interval [CI] = 0.09 to 0.72) in the study was lower than those reported by other reviews (e.g. effect size range of 0.57 – 1.11) (Kiely & McPherson, 1986; Milne & Covitz, 1988; Donnan, Hutchinson, & Paxton, 1990; Sorby, Reavley, & Huber, 1991; White, 1995; Holdsworth, Paxton, & Seidel, 1996; Chalder, Wallace, & Wessely, 1997; Kupshik & Fisher, 1999). This could be due to differences in the severity of the patients' symptomology or their motivation for treatment. It could also be that control patients in primary care trials were more likely to be receiving medication or other interventions than control patients used in trials that were not carried out within a primary care service.

The Bower *et al*. (2001) review provided detailed information about the inclusion criteria and search strategy and offered a full definition of what they believed 'self-help' to be. However, due to the inclusion criteria, only a small number of studies were appropriate and the methodological quality of these studies was relatively low, being vulnerable to allocation bias and small sample sizes. Despite this, the authors acknowledged the limitations and provided rationales for proceeding with a more focused review, explaining its relevance to primary care. Overall, the reported effect sizes calculations of self-help treatments are in the moderate range (Cohen, 1988). Despite the limited number of included studies within this review (Bower *et al*., 2001), the importance of these findings suggest that further evidence, both in quality and quantity, is needed concerning the clinical and cost effectiveness of self-help treatments, in particular the use of theoretically relevant psychological measures such as, preferences and expectancy, as mediators of outcome (Bower *et al*., 2001).

Den Boer and colleagues' (2004) meta-analysis shows a robust effect of self-help treatment for anxiety and depression, being significantly more effective that placebos or waiting lists (effect size = 0.84), equaling the results of

cognitive therapy in depressed patients (effect size = 0.82) and being larger than the effect size of anti-depressants (0.50). Additionally, Anderson and colleagues (2005) identified studies that had investigated the effectiveness of self-help interventions in relieving the symptoms of depression, and their meta-analysis indicated that self-help was an effective intervention. They found a difference of 1.36 standard deviations between the self-help group and control group. However, the evidence was drawn from small studies, making meta-analysis unreliable whereby caution is required during interpretation.

Moderating Variables

Whilst there is a developing body of evidence that self-help interventions can be effective, the evidence is not consistently positive (Richards *et al*., 2003; Mead *et al*., 2005). There can be a significant variation in clinical effectiveness beyond that expected by chance, which may be associated with factors such as the quality of study design, patient populations and the context of care, or may relate to differences in the actual design of self-help interventions. Therefore, understanding the contribution of such 'moderators' is important for the design of future interventions. Despite several reviews being conducted (Bower *et al*., 2001; Den Boer, Wiersma, & van Den Bosch, 2004; Anderson *et al*., 2005), the small number of studies have meant that they have been unable to measure key moderators.

A meta-analysis on the outcomes of moderators to identify what makes self-help interventions effective in the management of depressive symptoms has been conducted (Gellatly *et al.,* 2007). They wanted to determine whether the content of self-help interventions, the study populations or aspects of the study design were the most important moderators. They identified randomised trials of the effectiveness of self-help interventions versus controls in the treatment of depressive symptoms using previous reviews and electronic database searches. Effectiveness was associated with recruitment in non-clinical settings, patients with existing depression, contact with a therapist and the use of CBT techniques.

To elaborate on this further, smaller effect sizes were found in patients recruited from clinical samples rather than volunteers, and although this contradicts a previous review (Den Boer *et al.,* 2004) it is in accord with a

systematic review of brief therapy for depression (Churchill *et al.,* 2002). Self-help intervention may also be more effective with existing problems rather than in a preventative capacity. It was also suggested that self-help interventions should be based on CBT principles rather than education, although it was unclear whether other theoretical models would show equal efficacy to CBT. The results of the effect size found by the overall meta-analysis concerning the effectiveness of self-help interventions in Gellatly and colleagues' study (2007) was lower than previous studies, which reported effect sizes of 1.36 (Anderson *et al*., 2005) and 0.84 (Den Boer *et al*., 2004). However, this review included significantly more studies than previous reviews and used more liberal inclusion criteria. Because of this, a wide range of interventions were included ranging from educational booklets to more complex self-help technologies, rather than focusing on 'guided self-help'. They also had a wider variety of patients, such as those diagnosed with depression, depressive symptoms, stress, and those 'at risk'. The analysis was also limited by being restricted to short-term outcomes, as moderators of short-term benefits may differ from those that predict enduring effects. Interpretation of the results therefore requires awareness as meta-analysis of small trials can be unreliable, and the possibility of publication bias adds to the caution in drawing conclusions. Therefore qualitative methods may help provide a more fine grained analysis and more detail concerning the optimal methods of delivering self-help interventions.

Understanding the way in which such interventions achieve their clinical effects is important for both scientific understanding and effective clinical delivery. However, whilst establishing the effectiveness of self-help is important, patients' use of services is also dependent to an extent on their experiences and expectations (Rogers, Oliver, Bower, Lovell, & Richards, 2004). Previous experience with such services and the expectations that those experiences produce can govern whether a patient uses those services (Chapple & Rogers, 1999). Qualitative methods can illuminate both patient experience and possible moderating variables of guided self-help (Chapple & Rogers, 1999). They may therefore develop further understanding about how interventions are used and experienced (Donovan *et al*., 2002).

A meta-synthesis of qualitative studies was carried out by Khan and colleagues (2007), exploring patients' experience of guided self-help in primary

care in order to develop an explanatory framework and apply it to the development of a guided self-help intervention for depression. A number of themes were revealed which included the nature of personal experience in depression, help seeking in primary care, control and helplessness in engagement with treatment, stigma associated with treatment, and patients' understanding of self-help interventions. The application of these findings to guided self-help was particularly useful, as they could easily be used by professionals when considering such an intervention. For example, a number of key issues were highlighted that may affect the success of the introduction of guided self-help in primary care. These include the importance of issues of control and social functioning among patients, and the need to ensure that the context of primary care is viewed as a suitable location for mental healthcare. Furthermore, it supports the active role of the patient that is required in guided self-help, and attempts to actively engage with patients own constructions of depression and anxiety and their current coping strategies. However, whilst this synthesis demonstrated crucial factors for an explanatory framework, not all the papers focused on guided self-help *per se*, instead detailing views about depression and anxiety, quality of care for depression, experiencing depression and taking medication. Furthermore, some of the papers included in the synthesis were published by the same authors, which questions whether the results were weighted towards issues identified in the authors previous work.

Patient attitudes towards guided self-help were explored by Macdonald, Mead, Bower, Richards, and Lovell (2007). They examined patient expectancies concerning psychological therapy interventions, the degree to which their experience of guided self-help met those expectancies, and the effect of expectancies and experience on patient decision making about seeking further psychological therapy. Patients on the waiting list for psychological therapy services were offered rapid access to guided self-help prior to their first therapy appointment. They were required to have a minimum level of depression and a three month wait for their conventional psychological therapy. The sample of 24 participants consisted of 20 (83%) women and four men. Qualitative interviews were conducted with participants three to four months after they had received guided self-help for depression or anxiety, and

transcripts were analysed line by line to allocate data and processed through the QSR NUD.IST software.

Macdonald *et al.* (2007) found that expectancies did play a role in determining patient attitudes and highlighted that important gaps exist between expectancies of psychological therapy and the guided self-help experience. Participants expressed unfulfilled expectancies regarding the process and outcome such as, issues related to time, sharing personal problems and acquiring insight into the cause of the difficulties. They argued that whilst guided self-help must meet the criteria for an evidence-based treatment, the emphasis should be placed on patient views and 'person centred' services. However, this study used a population where patients' experienced more moderate to severe depression, whereas inclusion for guided self-help is for people with more mild depression or anxiety (Lovell & Richards, 2000). The patients were also offered guided self-help whilst on the waiting list for psychological therapy, indicating that they may have already developed an expectation of psychological treatment.

In summary, the empirical findings suggest that guided self-help may be moderately effective. However, the evidence is not entirely clear as other moderating variables may affect the significance of its clinical effectiveness. It has been suggested that more research, both quantitative and qualitative, needs to be conducted in order to understand these variables in more detail.

1.7 Extended rationale

Research that has been conducted on the use of guided self-help has focused mainly on its effectiveness to increase the evidence-base; hence, quantitative methodology has been employed. Whilst more qualitative research has begun to develop in the area of guided self-help, particularly surrounding its acceptability and accessibility to patients, there appears to be little research investigating patients' actual experience of guided self-help, as their views can often be different to the therapists (Fuller & Hill, 1985; Llewelyn, 1988). Patients' perspectives may enable researchers to clarify aspects of guided self-help which have been less comprehensively explored in the literature. This study therefore raises interesting questions about the necessary factors involved in guided self-help that contribute to alleviating patients levels of distress. It has

been suggested that where there is a concern with understanding processes, and the purpose of the research is to unravel complicated and slowly evolving events, then qualitative approaches are highly useful (Smith, 1996). Inductive analysis of the data may allow perspectives on the patient's experience to emerge which will provide a direction for research which may clarify the process of guided self-help.

Section Two: Methodology

Table 2

2.1 Overview of Research Design

Paradigm	Guided Self-Help
Methodology	IPA Proposal Ethical and R&D Approval Participant Identification Recruitment Information Letter Reply Slip
Data Collection	Interviews Transcription
Data Analysis	IPA Procedures
Findings	Superordinate Themes Subordinate Themes
Write-up	Discussion

2.2 Context of Service

This study was conducted within a Primary Care Trust. The primary care mental health team in this Trust works within a stepped-care model and provides sessions of guided self-help for patients with mild depression and anxiety. Patients initially saw their GP and were offered either medication and/or a referral to a triage clinic with a Community Psychiatric Nurse (CPN). A standard screening assessment was conducted by the CPN, which included questions about presenting problems, current mood/anxiety, diet and sleep, social support and risk (e.g., self harm, suicide, alcohol use, drug use, smoking, thought disorder). If there were symptoms of depression or anxiety with low level risk (e.g., low risk of self harm, suicide, comorbidity, and drug or alcohol misuse) patients were then referred by the CPN to guided self-help where they completed six to twelve sessions, as recommended by NICE (2004) with a graduate mental health worker (GMHW).

2.3 'Overcoming' Manuals

Most guided self-help clinics use the 'Overcoming Depression' and 'Overcoming Anxiety' manuals developed by Chris Williams (2001, 2003). These manuals are presented in a workbook format with ten workbooks in each manual and are based on cognitive-behavioural principles. The self-help approach is seen to fit well with CBT whereby patients are encouraged to carry out work between sessions in order to challenge unhelpful thoughts and behaviours (Anderson *et al*., 2005). The manuals focus on issues which are common to people with depression and anxiety, for example, negative thinking, reduced activity and how to overcome practical problems. The aim of these clinics therefore is to encourage the patient to implement and reflect on their learning, help them to improve their skills to manage their difficulties and increase their confidence in self management. It is a structured approach that requires patients to act on the advice provided within the self-help material, use the opportunity for new adaptive learning and produce changes outside of the clinical setting.

2.4 Recruitment of Participants

Participants were approached by the GMHWs about taking part in the study at the end of their guided self-help clinic. Each potential participant was provided with an information sheet (see Appendix A) by the GMHW, alongside an explanation about the study, and was asked whether they would be interested in taking part. The information sheet informed participants about the aims of the research and the level of anonymity and confidentiality. The researcher's contact details were also provided for further queries. Finally, participants were informed that participation in the study was entirely voluntary and that withdrawal from the study would not affect the care that they received.

Participants were asked to post a reply slip (see Appendix B) to the researcher which indicated whether or not they wanted to take part in the study (a prepaid reply envelope was provided). If they agreed to take part participants also provided contact details on the reply slip. Participants were recruited by contacting them once their reply slip had been received stating that they wanted to take part in the study. The researcher telephoned each participant to arrange a time and place for the interview to proceed. This was either at a local NHS clinic or at the participant's home address. Prior to the interview taking place, participants were asked to sign a consent form (see Appendix C) to indicate that they were happy for the interview to take place.

Criteria for offer of guided self-help and participation in the study:

Inclusion criteria:

- Type of problem: Depression or Anxiety
- Severity: Mild to moderate (As directed by the stepped-care model)

According to the Patient Health Questionnaire (PHQ9 – completed as part of clinical practice), scores of 5, 10, 15 and 20 represent cut-off scores for mild, moderate, moderately severe and severe depression respectively. Therefore mild depression was represented by a cut-off score of 5 and moderate depression was represented by a cut-off score of 10. According to the Generalised Anxiety Disorder (GAD7 – completed as part of clinical practice), scores of 5, 10, and 15 represent the cut-off scores for mild, moderate and severe anxiety respectively. Therefore mild anxiety was

represented by a cut-off score of 5 and moderate anxiety was represented by a cut off score of 10.

- Participants had completed guided self-help up until an agreed ending point.
- It was the participants first time of accessing help from a mental health service.
- Participants also needed to be able to read English, as they were required to read the workbooks provided as homework from the sessions.

Exclusion criteria:

- Participants on the waiting list for psychological therapy.
- Participants with previous psychiatric history. Defined as receiving previous intervention from a mental health/psychological service.

2.5 Data Collection and Construction of Interview Schedule

Interpretative Phenomenological Analysis (IPA) works with transcripts of semi-structured interviews and since phenomenological research requires the researcher to enter the life-world of the participant, it was important that the questions asked were open-ended and as non-directive as possible (Willig, 2001). Smith and Eatough (2006) argue that semi-structured interviews allow a flexible approach to data gathering for IPA and give a central place to understanding the individual's experiences and meanings while maintaining an awareness of the contextual factors surrounding the interview. Smith and Osborn (2008, p. 54) stated that the term 'understanding' is useful for IPA because it encompasses two aspects of interpretation, one of 'understanding in the sense of identifying or empathising with' and 'understanding as trying to make sense of'. With both aims in mind, the IPA interview is led by the participant but guided by the researcher, who is both empathic and questioning. After reviewing relevant literature for this study, the questions were chosen by the researcher, research tutor and clinical research supervisor in relation to the hopes of what the interview would cover. Therefore, a broad range of themes were used, i.e., 'expectation', 'experience', and 'changes'. The themes were placed in the most appropriate sequence, in this case, it followed the concept of time, i.e., before, during and after guided self-help, and appropriate questions

were thought of in relation to each theme, with possible prompts which followed on from answers. The purpose of the questions was to provide participants with an opportunity to share their personal experience of guided self-help, and reflect on whether their actual experience matched their initial expectations. Because the interview schedule was such an important part of the process, a pilot interview was conducted with a peer. This was helpful in relation to the wording and ordering of questions. The schedule was used flexibly throughout the interviews, with interviews being guided by the schedule rather than directed by it. Focused and more specific questions were used to encourage participants to elaborate on their descriptions such as, 'can you tell me more about…?', 'how did that make you feel when….?' (see Appendix D). By using this method there was an attempt to establish rapport with the participant, there was less importance on the ordering of the questions, and the researcher was freer to probe interesting areas that arose and follow the participants' interests and concerns (Smith, 1995).Whilst the most frequent form of data collection for IPA studies is semi-structured interviews, other methods could have been used to collect the data such as the use of diaries (e.g., audio, video or written) or other various forms of writing (Willig, 2001). However, a semi-structured interview allows the researcher to follow up interesting avenues that emerge so that the participant is able to give a fuller picture, something that may have been lost if another method had been adopted (Smith, 1995). More recently, there has been discussion about the use of 'focus groups' to collect data for IPA studies. However, further work is required to determine the meaning of findings from these contexts, particularly the impact that a 'group' of individuals might have on the double hermeneutic (Smith, 2004). Flowers, Duncan, and Knussen (2003) have presented a combination of focus group and individual interview data, while focus group data alone have been presented elsewhere (e.g., Dunne & Quayle, 2001). The focus group method was defined by Morgan (1997) as a research technique to collect data from the interactions between people who had been brought together by a researcher to discuss a particular topic. Focus groups originated in market research in the 1940s, since which time they have been used in business studies, health related studies and social science research (Rezabek, 2000). In 2004 Smith described using focus groups for IPA as an "area ripe for exploration" (p. 50) while urging a degree of caution. Smith

is concerned that the idiographic nature of IPA should not be lost and recommends parsing (discovering ways in which sentences are structured) focus group data repeatedly, for individual narratives, group patterns and group dynamics. Like many phenomenological approaches IPA is individualistic and concerned with explaining individual experiences (Langdridge, 2007).

2.6 Ethical Considerations (see Appendix E for ethical approval letter)

2.6.1 Consent: The participant information sheet outlined the broad aims of the study, the procedure, rights to withdraw and terms of confidentiality. This ensured that participants could make an informed choice as to whether to take part in the study. Consent was assumed through completion of the reply slip to say that they would like to take part and then a formal consent form was completed prior to the interview taking place. If participants had any questions or concerns, they were encouraged to contact the researcher whose telephone number and email address were provided. From there, any concerns would be raised with supervisors and participants would be signposted to appropriate supports. In the event, however, no participant contacted the researcher in this way.

2.6.2 Confidentiality: The Data Protection Policy and Guidance was adhered to at all times. There has been limited access to data and personal details, and they have been stored in a locked cabinet within a lockable room. The audiotape was destroyed once transcription had been completed, and all identifiable information has been removed from the transcripts in order to maintain anonymity. The ID numbers have been stored on the university computer, which has been password protected.

2.6.3 Withdrawal: Participants were free to withdraw from the study at any time, either prior to the interview taking place, or after completing the interview, as their transcripts contained ID numbers. However, no participant has come forward to withdraw from the study.

A key ethical consideration for this study was that talking about treatment for a mental illness can be a sensitive subject for participants to discuss. To address this there was a plan to:

a. Reassure participants that all personal information will be kept confidential. Participants were provided with an information sheet which provided the aims of the study, the level of anonymity, and confidentiality. Furthermore, participants were informed of their right to withdraw from the study at any stage without giving a reason.
b. Provide full contact details of the researcher & emphasise that they can contact the researcher with any concerns or queries that they may have.
c. Provide contact details of other services such as, GP, Samaritans, if they felt that they needed further support with any difficulties.

If a situation arose where the participant became distressed during the interview, then the interview would have been stopped and reassurance provided. However, as it was treatment that was discussed rather than diagnosis, this did not occur.

Furthermore, participants were told that they were welcome to stop the interview at any time. Oakley (1981) has highlighted the ethical implications around an imbalance of power in the interview context (with a focus on feminist research), suggesting that it is unethical to 'mine' the interviewee for information whilst the researcher provides none. This implies that the interviewer is in a position of advantage in steering the conversation towards relevant topics, however, the interviewee is the 'expert' in IPA interviewing and this was made clear to all participants at the start of the interview.

2.7 Theoretical Underpinnings of IPA

IPA was chosen for the present investigation. IPA is a form of qualitative inquiry and analysis that seeks to understand what an individual thinks or feels about a phenomenon (Smith, 1996; Smith, Jarman, & Osborn, 1999). It is a version of the phenomenological method which accepts the impossibility of gaining direct access to the lifeworlds of participants (Smith, 1995) and is therefore concerned with the *interpretation* of phenomena regarding lived experiences and how participants themselves make sense of their experiences (Langdridge, 2007).

IPA is phenomenological in that it attempts to explore an individual's personal perception or account of an event as opposed to attempting to produce an objective record of the event itself (Smith *et al*., 1999). Finlay and

Ballinger (2006) highlighted how phenomenology is both a philosophy and an approach to research, which allows in-depth exploration of how phenomena appear to us in our consciousness and the nature and meaning of such phenomena. As such, IPA is an inductive approach concerned with understanding an individual's personal account of a particular experience or phenomenon, rather than trying to find causal explanations for events or produce objective 'facts' (Smith & Osborn, 2008).

Phenomenology as a philosophy was developed by Husserl (1962, 1970) and later extended by philosophers such as Heidegger (1962) and Gadamar (1975). Husserl's transcendental phenomenology focuses on the 'life world' of an individual and regards experience as the fundamental source of knowledge (Dowling, 2007). It argues that the 'essence' of a phenomenon can be understood by revisiting a person's immediate conscious experience of it prior to any reflections or explanations being imposed. Although IPA is clearly influenced by Husserlian phenomenology in its aim of understanding the individual's experience, it does not seek to bracket the researcher's values and beliefs. Instead, it views these as necessary in understanding and making sense of the person's experiences (Shaw, 2001). In addition to the phenomenological focus, the influence of Heidegger's hermeneutic phenomenology on the development of IPA is therefore seen through the emphasis placed on interpretation and the role of both participant and researcher in a dynamic research process. Heideggerian phenomenology is concerned with 'Being' (*Daesin*) and 'Being-in-the-world' and places significant emphasis on understanding (*verstehen*) rather than description (Finlay, 1999). Unlike Husserl, Heidegger emphasised that there is always an element of personal engagement that arises from being 'thrown into the world', where some events, objects and experiences have more meaning and purpose than others, and that these form the basis for interpreting and making sense of our experiences (Wilding & Whiteford, 2005).

IPA acknowledges that it is not possible to have direct access into someone's 'life world' because this is influenced by the researcher's own experiences, values and pre-understandings, which are considered necessary in interpreting and making sense of an individual's experiences. Smith and Osborn (2008, p. 53) referred to this dual process as a double hermeneutic,

whereby 'the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world'. The term interpretative phenomenological analysis is therefore used to signal the dual facets of the approach (Smith *et al*., 1999). Overall, IPA is phenomenological in that it seeks an insider perspective on the lived experiences of individuals and interpretative in that it acknowledges the researcher's personal beliefs and standpoint and embraces the view that understanding requires interpretation.

Smith (1996) describes a split in social psychology between traditional quantitative paradigms and 'alternative epistemological and methodological approaches', specifically between social cognition and discourse analysis (Smith, 1996, p. 261). IPA is suggested as potentially compatible in this regard with both approaches (Clare, 2003). In comparison with content analysis, which seeks to produce a quantitative analysis of discrete categories from qualitative data, the importance of the narrative portrayal in IPA remains paramount, with the final analysis providing a detailed interpretative analysis of themes. IPA also starts with, but should go beyond, a standard thematic analysis. Essentially, thematic analysis is a search for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997) and involves identification of themes through 'careful reading and re-reading of the data' (Rice & Ezzy, 1999, p. 258). It is a form of pattern recognition within the data, where emerging themes become the categories for analysis. However, it is the emphasis on 'interpretation' that moves the IPA researcher away from simply describing the individual's experience, achieved in thematic analysis, towards a detailed interpretation and collation of analysed themes that stem from participants narratives (Smith, 1999).

Qualitative research is a diverse field situated within a series of debates with quantification, e.g., natural vs. artificial settings, induction vs. deduction, identifying cultural patterns vs. seeking scientific laws (Hayes, 1997). A dominant theme within qualitative research is the explication of meaning, which requires a certain level of inference. However, qualitative approaches have been criticised for the space they afford the subjectivity of the researcher. This issue appears to be a pertinent one within psychological science as psychology has traditionally been based in positivism and is therefore concerned with

establishing objective and reliable methods of investigation (Madhill, Jordan, & Shirley, 2000).

A positivist position is the belief in a real world where knowledge can be gained through the use of scientific methods, and often includes quantification of psychological phenomena and the use of inferential statistics. For many social science researchers, positivism has been superseded by post-positivism, where a real world is still assumed but our knowledge of it is critical and therefore never complete and is only an estimate (Guba, 1990). Although positivism/post-positivism may be appropriate for the natural sciences, some argue it is inappropriate for psychology and the study of human experience because a great deal of information is lost in efforts to reduce phenomena to standardised measures. Consequently, there has been development of many different epistemological positions for psychology.

Epistemology is the branch of philosophy concerned with knowledge and what can be said about the world and the relationship between the knower and the known (Langdridge, 2007). As a way of imposing order on this diversity, Madhill and colleagues (2000) have outlined three epistemological strands (*realist, contextual constructionist and radical constructionist).* Three *realist* epistemologies were distinguished: naïve, scientific and realist. Naïve realism declares an association with theory of truth, believing that the world is largely knowable and just as it appears to be. Scientific realism adds that although imperfect, the scientific method can utilise true representations of the world and is the best mode of inquiry. Critical realism, however, contends that, 'the way that we perceive facts, particularly within the social realm, depends partly upon our beliefs and expectations' (Bunge, 1993, p. 231). Hence, critical realism admits an inherent subjectivity in the production of knowledge and has much in common with constructionist positions.

However, researchers working within a *contextualist* or *radical constructionist* epistemology are more likely to reject a straight forward transference of criteria such as objectivity and reliability into the evaluation of their work. In contrast to a naïve or scientific realist framework, it does not assume that one reality can be revealed through the use of correct methodology. It is the position that all knowledge is local, provisional, and situationally dependent (Jaeger & Rosnow, 1988) and states that results will

vary according to the context in which the data was collected and analysed. The *radical constructionist* position in particular is characterised by a distrust of the idea that language can present an accurate picture of an underlying reality. Rather than consider objects to be the foundation of representations, representations are understood to construct the objects which then come to populate the world.

Pidgeon and Henwood (1997) identify four dimensions which may affect the production of knowledge: participants' understandings, researchers' interpretations, cultural meaning systems which inform both participants' and researchers' interpretations and acts of judging particular interpretations as valid by scientific communities. Research is therefore concerned with completeness rather than accuracy of representations (Willig, 2001).

Traditionally, IPA is theoretically rooted in critical realism (Bhaskar, 1978) and accepts that there are stable and enduring features of reality that exist independently of human conceptualisation. However, a critical stance towards knowledge is taken whereby there is recognition of historical and cultural influences on claims that are made in psychology (Langdridge, 2007). Differences in the meanings individuals attach to experiences are considered possible because they experience different parts of reality.

2.8 Data Analysis

IPA is inductive in nature, allowing ideas and themes to emerge from the personal accounts rather than imposing a predetermined theory, thus opening up the researcher to possibilities that had not been considered. The approach adopts both *emic* (insider) and *etic* (interpretative, outsider) positions (Reid *et al*., 2005). The emic position enables the researcher to hear and understand *a* participant's story and place his or her experiences at the centre of the account. Adopting the etic position involves the researcher trying to make sense of the data by bringing in his or her own interpretations and theoretical ideas, but using verbatim quotes to ground these interpretations in participants' actual experience. Reflexivity, therefore, is an important and indeed central part of IPA in ensuring that the researcher remains aware of how his or her personal experiences and pre-understandings are influencing data analysis (Finlay, 2008).

Whilst the provision of guidelines to analyses serves to foster the accessibility of IPA, such guidelines are intended for adaptation and development rather than stagnating the development of the approach (Smith, 2004). Not all researchers proceed with their data analysis in the same way and Smith and colleagues (1999) explicitly state that it is not appropriate to provide a prescriptive methodology for IPA. In comparison to other methodologies, whilst there is a basic process to IPA (moving from the descriptive to the interpretative), the method does not seek to claim objectivity through the use of a detailed, formulaic procedure.

2.9 Quality Assurance Measures

The criteria for judging the excellence of quantitative research is relatively well established, for example, representative samples of adequate size, balanced design which minimises confounding variables, reliable measures, appropriate statistical analysis, etc (Yardley, 2000). In contrast, the conventions and standards for the conduct and evaluation of qualitative research are difficult to define and consequently risk evaluation by criteria that are irrelevant to a particular approach, and by individuals who are unfamiliar with the methods and rationale that have been adopted (Stern, 1997). The exercise of sufficient rigour and validity to establish the credibility of qualitative research is considered to be no less essential than in any other form of research. However, it is important that the criteria by which it is judged are appropriate because it is argued that qualitative research needs to be compatible with an epistemological framework of the research that is being evaluated (Conrad, 1990; Stiles, 1993; Smith, 1996; Madhill *et al.,* 2000).

The source of the dispute about the credibility of qualitative research can be traced to being embedded in a philosophy of knowledge development that differs from the philosophy supporting the quantitative approach to knowledge development in social sciences (Elliott, Fischer, & Rennie, 1999). Whilst qualitative researchers recognise the need to establish agreement as to the validity of a piece of research, most reject the idea that there could or should be a universal code of practice for the use of qualitative methods (Feldman, 1995; Greenhalgh & Taylor, 1997; Guba, 1992). However, there is a need to agree

upon equally open-ended and flexible ways of assessing quality, which are applicable to many qualitative methods.

Qualitative research is often criticised for failing to employ a representative sample, to develop reliable measures, or to yield objective findings or replicable outcomes. However, a sample size large enough to be statistically representative cannot be analysed in depth, which consequently undermines the rationale for employing qualitative methods. It is therefore preferable to employ samples of small numbers of people (Charmaz, 1990; Smith, 1996).

Jarman, Smith, and Walsh (1997) recommend that IPA researchers should take particular care in their production of lists of themes to ensure that each theme is actually represented in the transcripts. Smith and Osborn's (2008) guidelines recommend that care is taken to distinguish between the participant's original account and the analyst's interpretations. The centrality of researcher subjectivity in this kind of work means that traditional research evaluation criteria such as representative samples and appropriate statistical analyses are irrelevant (Touroni & Coyle, 2002; Yardley, 2000). Verbatim extracts from transcripts provide 'grounding in examples' (Elliott *et al*., 1999, p. 222) which, acting as alternative criterion, allows the reader to make his or her own assessment of the quality of interpretations made in the analysis.

As a qualitative research method, IPA is inevitably subjective as no two analysts working with the same data are likely to come up with an exact replication of the others analysis. Although this fact is recognised and welcomed by advocates, for others this raises questions about validity and reliability (Golsworthy & Coyle, 2001). Some analyses are checked and interpretations validated by other academics or professionals, either involved in the research (e.g., Smith, Michie, Stephenson, & Quarrell 2002; Alexander & Clare, 2004) or independently (e.g., Turner & Coyle, 2000; Robson, 2002). Some researchers ask participants for feedback on preliminary interpretations (e.g., Smith, 1999; Turner & Coyle, 2000; Alexander & Clare, 2004). However, Yardley (2000) argues that reliability may be an inappropriate criterion against which to measure qualitative research if the purpose of the research is to offer just one of many possible interpretations. It is often acknowledged that the themes examined to be a subset of the total themes extracted, focus on the data from a

particular viewpoint (e.g., Smith, 1999). This is in keeping with IPA's recognition of the researcher's interactive and dynamic role. For those who question the objectivity of knowledge, the use of 'inter-rater reliability' measures merely produces an interpretation agreed by two people rather than functioning as a check of objectivity (Yardley, 2000, p. 218). The aim of validity checks in this context is to not prescribe to 'the singular true account' but to ensure the credibility of the final account (Osborn & Smith, 1998, p. 69).

Yardley (2000) has produced a useful set of guidelines for judging the validity of qualitative research, highlighting four broad topics: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. First, there is a need to be *sensitive* to the theoretical *context* of the study and findings from previous research, and have a good grounding in the philosophy underpinning the methodology being employed. Yardley (2000) also argues the importance of awareness of the relationship between researcher and participant, including the balance of power. *Commitment* relates to the competence and skill of the researcher and the time engaged with the topic, and *rigour* refers to the completeness of a set of data (i.e. adequate sample) and completeness of the interpretation. The data collection process and analysis therefore need to be thorough and systematic. *Transparency* and *coherence* relate to the presentation of findings, which need to be clear and rational, as the communication of findings to peers is a vital part of the research process (Langdridge, 2007). Subsequently, it is important to ensure that (i) information is provided about data collection and the analysis, (ii) evidence is provided in support of the claims being made and (iii) the influence of the researcher on the production of the findings is described, through a discussion of reflexivity, as mentioned above. *Impact* and *importance* relates to the affect that research can have on patient's beliefs or behaviour.

Avis (1995) argues that validity is in the establishment of the credibility of research findings, and contends that there can be no formal set of criteria to judge the validity of qualitative research findings. Rather the credibility of research findings should be judged on the usefulness of the research project.

There are no 'easy' solutions to limit the likelihood that there will be errors in qualitative research. This study deployed several ways of improving reliability and validity and these will be detailed here (i.e., audit trail and

reflexivity), alongside techniques that were not used (i.e., bracketing, member checking and triangulation).

Bracketing

Bracketing, also known to phenomenological theorists as epoche, may be described as a self aware act of suspending judgments about reality. Traditionally, researchers carrying out phenomenology studies have aimed to 'bracket out' their preconceptions (Colaizzi, 1978; Moustakas, 1994) using formal reflexive techniques (Heron, 1990; Duck, 1992). This might mean, for example, abandoning subjective assumptions about what is held to be of importance by another human being and why. Bracketing is a common strategy in qualitative research to identify and control for bias and entails researchers setting aside their own research propositions and theoretical frames of reference during the research in order to recognise the phenomena more clearly and to alleviate against bias, influence or presumptions. However, Reynolds (2003, p. 555) has argued that bracketing is very difficult in IPA, if not 'conceptually impossible'. IPA requires the researcher to use experience and theoretical assumptions to influence and contribute to the research process.

It has been argued that true phenomenological research should also require respondents to engage with these reflexive techniques in order to give a more accurate representation of the way in which they see the world pre-cognitively (Caelli, 2001). From this standpoint it could be argued that IPA has been wrongly labelled as 'phenomenological'. Smith and colleagues (1999) stress that the purpose of IPA is to attempt as far as possible to gain an insider perspective of the phenomenon being studied, whilst acknowledging that the researcher is the primary analytical instrument. The researcher's beliefs are not seen as biases to be eliminated but rather as being necessary for making sense of the experiences of other individuals.

Member Checking

Member checking includes techniques in which the researcher's account is compared with those of the research subjects to establish the level of correspondence between the two sets (Mays & Pope, 2000). This is one of the most discussed techniques in the attempt for rigour and claims that the report

derived from this process authenticates data and contributes to the rigour of the research process (Koch & Harrington, 1998). However, it has its limitations and the benefit to be gained is questionable (Mays & Pope, 2000). As far as the basic data is concerned, the interviews were audiotaped and directly transcribed, which provides a guarantee of verbal accuracy at least. With regards to the analysis and discussion, the method included individual statements under many different themes and it would have been extremely difficult for participants to identify his or her contribution. Furthermore, member checking assumes that there is a fixed truth of reality, whereby an account made by a researcher is confirmed by a participant. However, as IPA is rooted in critical realism, there is acceptance that there will be a natural subjectivity when producing and understanding information. Taking these factors into account and given the time and travel constraints of the research process, member checking was deemed an inappropriate technique to utilise in this case.

Triangulation

Triangulation compares the results from either two or more different methods of data collection, for example, interviews and observation, or two or more data sources, for example, interviews with members of different interest groups. The idea is to look for patterns of convergence to develop an overall interpretation (Mays & Pope, 2000). Triangulation does not appear to play an equivalently important role in IPA where the emphasis throughout remains on discussing idiographic findings in relation to the existing psychological literature. Some qualitative researchers may adopt triangulation techniques in an effort to enhance further the quality of their studies; perhaps particularly with regard to ongoing debates about qualitative findings and external validity (Gilchrist & Williams, 1999). However, it is also argued that, rather than triangulating to establish commonalities between perspectives, a number of different perspectives should be maintained. Breuer and Roth (2003) suggest that it is this plethora of perspectives that provides the richest source for knowledge production through the research process. Triangulation was not used in this case, as IPA acknowledges its subjective nature and recognises that the end result is the interpretation of the researcher. Given the double hermeneutic

principle, it would be unlikely that other peers/researchers would produce an exact replication. However, because IPA does not seek to use triangulation or samples that are representative of the whole population of interest, it has clear implications for claims about the external validity or generalisability of findings. IPA findings may be specific to the particular group of individuals sampled, who are representative only in as much they have personal experience of the topic being investigated. Salmon (2003) suggests that while claims to generalisability may be abandoned in qualitative research, it is not always clear what should replace them. Others (e.g., Touroni & Coyle, 2002) argue that knowledge can be advanced through detailed, qualitative analyses of small groups of individuals, which can produce useful insights into subjective experiences and processes. According to Smith and Osborn (2008), idiographic, IPA findings may subsequently lead to making claims for larger populations. Nonetheless, any claims for generalisation from IPA samples should be made with caution.

Audit Trails

Like other qualitative methods, it is essential that published research provides methodological details that allow others to confirm to its quality and utility. Curtin and Fossey (2007, p. 90) argued for a 'thick description' of research process and findings. This 'thick description' is similar to that termed 'audit trail' (Lincoln & Guba, 1985) and is crucial in IPA so that readers can follow the research process and make sense of subsequent data analysis. A research diary and field notes can record and reflect the researcher's own involvements in the research process, with particular reference to any biases or predetermined views. Such records can help to account for any influences on the data collection, analyses and final report (Cook, 2001) and will therefore be used in this study.

Reflexivity

To demonstrate excellence, research is expected to show the relationship between accounts and the contexts within which they have been produced. This applies to both the participants accounts, e.g., of their experience, thoughts and feelings; and the researchers accounts, e.g. their analyses and interpretations of data. Reflexivity and transparency will therefore

be important criteria for evaluation within this context as it will take into account the process in which the researcher is conscious of and reflective about the ways in which their questions, methods and own subject position might impact upon the psychological knowledge produced in this study (Langdridge, 2007). Personal and intellectual biases also need to be made clear at the outset to enhance credibility of the findings. Subsequently, it is recognised that the decisions made by the researcher at all points of the research will influence the findings (Finlay & Gough, 2003). This is true from the choice of literature, through methodological decisions, to the writing-up process itself (what information to include or leave out).

Section Three: Results

3.1 Audit Trail

Having followed the guidelines for an IPA analysis as described by Smith (1995), concepts from the first interview were noted in the form of a list of key phrases down the right hand side of the margin. At this stage, all of the interview content was being included, without selection by the researcher.

The preliminary list of emerging themes from the first interview was:

- Uncertainty
- Help seeking behaviour
- Choice
- Flexibility
- Awareness
- Understanding
- Reassurance
- Validation
- Normalisation
- Guidance
- Management

Subsequently, each of the remaining six interviews were read again and instances of the preliminary, identified themes were highlighted and noted in the right hand margins, along with annotation of any data that suggested new concepts that had not previously been found. At the end of this process, the key themes that had been extracted from all seven interviews were written on a separate sheet of paper and considered together. At this stage, the researcher was trying to see any relationships and to organise the preliminary list of key themes into clusters of connected ideas. The researcher then returned to the transcripts to check that each of the identified, preliminary clusters could be supported by verbatim text from the participants. Selecting themes for the richness of their representation in the raw data is concordant with the role of an IPA analyst in the research process being an interactive and dynamic one (Brocki & Wearden, 2006).

The themes that remained were clustered as:

- Access to resources
    - Improvement
- Help-seeking Behaviour
    - Motivation
- Structure
    - Individually tailored
    - Flexible
- Process
    - Normalisation
    - Self-Awareness
- Challenging
    - Cognitively
- Guidance
    - Non-judgmental
    - Validation
    - Motivating
    - Empowering
- Family and Friends
    - Motivating
    - Guilt
    - Burden
    - Conflict
- Outcome
    - Positive
    - Future resources
    - Management

Next, the researcher created a Word document in which these clusters were displayed as key themes and sub themes, with references to the page numbers and line numbers and examples of supporting quotations from interviewees. At this point, the researcher spent some time reflecting on this document and the psychological experiences that could be synthesised from it.

The researcher returned to the IPA literature to seek guidance during this time. Smith (1999, p. 424) suggests that:

> "...from an idiographic perspective, it is important to find levels of analysis which enable us to see patterns across case studies while still recognising the particularities of the individual lives from which those patterns emerge".

Furthermore, Smith argues that although an IPA researcher should be informed by the psychological literature, the data analysis should not be directed by any specific, prior theoretical position (Smith, 2004). A diary entry, posted by the researcher during the stage of identifying preliminary themes from the first interview, read: "I feel as though the themes are rather simplistic and I am concerned about their relevance to psychological literature". During a later entry into the diary following supervision with her research tutor, the researcher recognised that she was actually doing justice to her participants by being less theoretically driven. The final superordinate and subordinate themes were then presented as:

- Participants' intention to feel better
- Development of understanding and awareness
    - Comparing current self with previous self
    - Management rather than cure
- Change: From dependency to independence
    - Wanting Reassurance
    - Someone to spur you on
    - Feeling independent
- Relating to others
    - Decision to include family and friends
    - Wanting to feel understood
    - Family as a barrier

The theme, 'relating to others' will be described here in more detail.

3.2 Subordinate Themes: 'Relating to others'

3.2.1 Decision to include family and friends

Adam and Jane described how they valued the support that they received from family and friends and felt that completion of guided self-help would have been difficult without them as they were a motivating factor in the process. There was a sense that involvement of family and friends was a positive experience which encouraged them to partake in guided self-help.

> I think without the support of family and friends, I probably wouldn't have started on it in the first place.

> It is helpful to have another person there who knows what you're trying to do…things that you're trying to stop doing and can be encouraging with a bit of healthy challenging as well.

However, Margaret and Emma stated that for them, involving family and friends was difficult because they felt a sense of guilt about burdening others with their difficulties. This appeared to be exacerbated by the fact that both their families have a history of depression.

> My husband isn't really into feelings (…) my mum, I don't want to burden her because she's had depression herself and I don't want to worry her (…) so there's not (…) it's not always easy talking to family and friends.

> My mother (…) I knew she'd just worry about it and think, 'oh god another child with mental illness'. So I sort of mentioned it to her but certainly didn't go into any detail.

This was in stark contrast to Adam and Jane, who have no family history of anxiety and depression, and highlights differences in the value that people place on the support of their families and friends, depending on different contextual factors.

3.2.2 Wanting to feel understood

George in particular felt strongly that he did not want to involve his family, stating that he wanted to talk to somebody who would be able to understand his difficulties without having to explain everything. What appears significant here is the little expectation that George had about his thoughts and feelings being understood by his family and friends.

> I suppose if you were talking to an untrained person, whether it's your spouse, daughter, or parents or whatever, if they've never experienced these problems or don't know anybody who has experienced them then it's a little bit difficult for them to understand what you're talking about.

This comment reflects how it was important for George to experience support in terms of feeling understood without having to go into detail about discussing his feelings, and that it was desirable to be able to talk to somebody outside of the immediate family situation. He was looking for someone who might understand him and might offer some perspective on his difficulties, and who might be able to suggest ways of coping.

3.2.3 Family as a barrier

It appears that changes which have occurred in the individual through the process of guided self-help may be difficult for immediate family to accept, and may potentially act as a barrier if familiar patterns or ways of responding become difficult to break. For example, Rosie described how through the process of guided self-help she developed awareness that her passive behaviour had caused some of her emotional difficulties. She therefore began practicing assertiveness skills and described her difficulties of using these techniques with her husband:

> He said, 'I thought you've supposed to have learned how to be assertive' and that was quite hard because it was like he was throwing it back at me, the other way round (…) you don't necessarily like it when I do it to you but you should be able to do it with everybody else.

The focus that she was placing on guided self-help excluded direct involvement of her wider social system, which placed limitations on it. Her partner did not fully understand the process that she was going through, despite offering his support. For her, it would have helped if her partner had understood and experienced guided self-help. However, regardless of this, she has accepted that she feels better in herself and has learned to challenge her partner.

> I know that my husband was quite concerned that I was over analysing myself and I think he sort of expected that it would be like therapy and blame the husband ( ) We were in a car once and he said, 'I like my door mat' and he laughed but I know that I've challenged him now.

3.3 Reflexive account about 'participants' intention to feel better'

In terms of transparency in relation to interpretation of the data, particularly the superordinate theme, 'participants' intention to feel better', it is important to mention two aspects that may have impacted upon the data, firstly, the socioeconomic status of the participants and secondly, the researcher's personal influence.

Regarding socioeconomic status, all participants lived within an advantaged and privileged area. Of the five participants who were employed, they all had successful, high paid careers. One participant was a full-time mother whose husband had a successful career and another participant was studying law. Taking this information into consideration, it is important to examine the participants' drive to succeed as they all presented as high achievers with a willingness to succeed. They were therefore a particular population of people who acknowledged that they wanted to 'do something' to improve how they were feeling. It would appear that they are people who acknowledge that achievements occur through being proactive; hence, guided self-help was a successful option for them. Furthermore, participants were offered a choice of treatment with differing formats of self-help, i.e., computerised or guided. Therefore, participants could decide which treatment would work best for them and indicates that they may be more favourably disposed to this mode of delivery compared with other primary-care patients.

It is also necessary to acknowledge that this particular theme holds personal curiosity to the researcher in terms of understanding motivational aspects towards intervention for depression and anxiety. Having worked as a support worker for a guided self-help clinic (whilst employed as an Assistant Psychologist), the experience of low uptake levels for guided self-help sessions, and the knowledge that depression, in particular, is associated with low motivation, engendered a general curiosity. Were patients appropriately informed of guided self-help by their GPs? If so, what encouraged them to partake in guided self-help? What did they hope to achieve? What can be done to improve the service?

Section Four: Discussion

The main findings from this IPA study, elaborated over the three main superordinate themes, is that there were common experiences of self-determined motivation, increased understanding and awareness, and change in self-efficacy in all of the participants. Theoretical, empirical and clinical implications will now be considered and this discussion will be further developed into a consideration of the potential for elaborating further research.

4.1 Theoretical and empirical implications

There are a plethora of theories that could be related to the data, however only a few will be discussed here. Whilst in qualitative research rich and diverse empirical findings are wanted, cherry picking from a number of theories is likely to reduce rather than enhance understanding.

4.1.1 Motivation: Self-Determination Theory

The interesting finding from this current study was the participants' level of motivation to improve their mental health in a proactive way *prior* to accessing guided self-help. Participants described unclear expectations about guided self-help because they did not know what it contained, which reflects similar findings to Macdonald *et al.* (2007) whereby entering guided self-help involved access to support. However, the difference between the two studies is the circumstances in which participants were accessing guided self-help. In Macdonald *et al's.* (2007) study, participants were already on a waiting list for psychological therapy and wanted more rapid access to support. Whereas in the current study, participants were actively seeking help in which they could contribute to. Consequently, this study lends support to the Self-Determination Theory (SDT; Deci & Ryan, 1985) mentioned earlier in the background section. This suggests that factors such as patients' attitudes alone are unlikely to address the full range of influences impacting upon uptake levels of guided self-help. Additionally, this also has particular relevance to the issues of dropout, compliance, and maintenance of change (Pelletier, Tuson, & Haddad, 1997).

The degree to which individuals experience autonomy and get their psychological needs met depends on their tendencies to orient towards their environment in ways that supports their own autonomy, controls their behaviour, or are motivating. SDT proposes that there are different types of motivation for behaviour and these types of motivation can vary in the extent to which it is autonomous (self-determined) or controlled. SDT suggests that the most self-determined forms of regulation will guide behaviour when the three basic psychological needs are satisfied, this predicting better functioning and psychological well-being. In contrast, low self-determination is a consequence of the thwarting of psychological needs. In low self-determined behaviour a more controlled, external force is present and the individual feels pressured to engage in the behaviour, which leads to poorer functioning.

SDT describes varied types of motives that may bring a person to therapy and these motives, with corresponding regulatory processes, vary along a continuum of relative autonomy (Ryan & Connell, 1989; Vallerand, 1997), and people typically have varied degrees of each type of motive. Firstly, people can be pressured or coerced by external factors, a process referred to as 'external regulation', which is apparent in the treatment of children, and in therapies connected with the legal system such as substance abuse (Wild, Cunningham, & Ryan, 2006). Secondly, 'introjection' is evident when people initiate treatment because of "shoulds," guilt, or seeking social approval and thus pressure themselves to change. Thirdly, people may have the more autonomous experience of 'identifying' with the goals of therapy and have a desire to pursue change. This volitional identification will be transformed into 'integrated regulation' when it is brought into congruence with all of the person's values and perceptions. Finally, people may even come to treatment with considerable intrinsic motivation, reflected in an open curiosity and interest in what can occur.

It is this intrinsic motivation which appears to be congruent with the participants' narratives about their hopes of what completing guided self-help would achieve. When social events promote perceptions of being controlled or coerced, intrinsic motivation (i.e., interest and engagement in activities) is undermined. Conversely, when social events promote perceptions of autonomy support, intrinsic motivation toward activities is enhanced (Deci & Ryan, 2002). For these participants, they wanted to engage in a process that was going to

improve their well-being and the offer of guided self-help enhanced their intrinsic motivation. This general prediction has been supported by a large research literature, and across a variety of health behaviours that are often accompanied by social pressure (e.g., smoking cessation, weight control, adherence to medication; Westmaas, Wild, & Ferrence, 2002). Essentially, this finding illustrates that a self-motivated person is more likely to identify and control certain aspects of the environment that affect his or her behaviour. It also illustrates that participants did not enter guided self-help with a pre-conceived attitude about what treatment should involve as suggested in Macdonald *et al's.* (2007) study. They were prepared to enter any treatment as long as they could begin to improve how they were feeling. However, several participants acknowledged that they wanted to find out the initial cause of their distress, which coincides with Macdonald *et al'*s. (2007) study, but whereas their participants did not discover this information, participants in this study did discover this information, which they found beneficial to their experience.

Each of these motives and their regulations has its own dynamic presentation, but the less autonomous the motive the more SDT predicts poor engagement in therapy and lowered long-term, or maintained, success (Ryan & Deci, 2008).

Psychotherapy depends upon the continuing willingness of clients to recognise and work on specific, and frequently multiple, problem areas in their lives. Therefore, in most clinical encounters, treatment is an unfolding process, the goals of which are sometimes changing (Ryan & Deci, 2008). SDT therefore represents a broad theory of motivated behavior, built upon experimentally tested constructs and principles at both micro and macro levels (Ryan & Deci, 2008).

4.1.2 Therapeutic alliance

All participants understood that the therapeutic alliance was central in their positive experience of guided self-help and their increased confidence. This could potentially add to Beck and colleagues (1979) model by illustrating that the therapeutic relationship was considered by participants as essential in their overall experience and feeling safe to engage in techniques. Equally, this supports Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) finding that

difficulties may arise in treatment if the main focus is on the application of techniques without consideration of the interpersonal aspects. That is, encouraging someone to test their thoughts if they do not feel accepted might not be possible.

In contemporary applications of CBT, the primary emphasis is on having clients learn more effective skills for coping with life problems. It is this focus on technique that has historically relegated the therapeutic relationship to the category of 'nonspecifics' within the therapeutic intervention (Goldfried & Davila, 2005, p.423). The relationship has been considered to be nonspecific in two senses. Firstly, it is not viewed theoretically as being intrinsic to the learning process implemented by the technique. Secondly, it is viewed as something not readily defined or easily measured (Goldfried & Davila, 2005). Consequently, CBT researchers and practitioners regard its 'specific factors', referring to its 'empirically grounded clinical interventions' as the reason for its success (Richardson & Richards, 2006). As such, these specific techniques are generally held to possess their own therapeutic agency, with an emphasis on a direct and strong relationship between techniques and patient recovery (Richardson & Richards, 2006). However, despite the short-term nature of guided self-help, participants in this study regarded the facilitator as an essential factor in their experience of guided self-help, describing them as positive, understanding, validating, reassuring and motivating. Furthermore, working collaboratively with the therapist was regarded by the participants as an integral component of the therapeutic alliance, which has been proposed by some to be a major integrative concept and robust indicator of outcome (e.g., Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000).

In the same way that the alliance between therapist and patient is valued by patients as one of their most important mediators of therapeutic effect (Horvath & Bedi, 2002) this study supports other evidence that this common factor is equally important to patients in guided self-help. For example, Richards and colleagues (2004) qualitative study of a guided self-help clinic found that patients did not use technique based attributions of success, even where limited amounts of contact with a self-help facilitator were available. Instead, many patients used interpersonal attributional concepts, regarding their improvements as a consequence of 'having somebody to talk to' (p. 44).

The participants' experience of feeling understood and having their thoughts and feelings validated by a professional led them to feel more confident and independent, leading to a reduction in distress. From this experience, participants acknowledged that their depression or anxiety was perpetuated by unreliable thinking. These accounts of change could be seen to support Teasdale, Moore, Hayurst, Pope, Williams, and Segal's (2002) theory that accepting and allowing what is, without a pressure to change it, leads to reduction in distress. Problematic emotions and experiences appeared to be assimilated as a result of this, which might relate to Stiles *et al's*. (1990) assimilation stage in their stages of change model. This will be discussed later in the paper. Motivation has also been regarded as an important determinant of client involvement in productive collaborative therapeutic work (Marmar, Gaston, Gallagher, & Thompson, 1989) and it has been suggested that motivated patients are more willing to commit to the tasks of therapy and tolerate the strains inherent in working through conflictual themes.

4.1.3 Therapeutic change

In considering this current study, another main finding was that there were common experiences of belief change in the area of self-efficacy. Derived from work by Bandura (1997), self-efficacy represents feelings of confidence in one's ability to perform that behaviour. Essentially, self-efficacy is a subjective assessment of an individual's ability to perform a necessary behaviour in order to achieve a future state (Janzen *et al.*, 2006).

Despite participants having the self-determined motivation to access guided self-help, they described how they would have felt unable to guide themselves appropriately through the self-help materials. Initially, participants in this study described a need for guidance in the beginning stages of guided self-help and felt that they would have become overwhelmed with the self-help workbooks without that support, reporting that they would have wanted to have worked through everything as quickly as possible, and in their view, end up failing. This illustrates a lack of self-efficacy in their ability to perform the task of self-help. However, throughout their sessions of guided self-help, participants reported feeling more confident and empowered to utilise the self-help workbooks, illustrating an increase in their perceived capability. They had

become responsible for their own changes and had developed self-initiated attempts to control their behaviour. Participants believed that adopting a change in their behaviour would result in improved health, that the change was worth the effort, and that they could accomplish the tasks required for change. Similarly, self-efficacy influences the effort that individuals put into achieving particular goals by affecting their determination to achieve (Bandura, 1977) and further highlights and supports how self-efficacy is an important determinant of behavioural change. However, whilst stronger self-efficacy influences more active efforts (Bandura, 1977), low self-efficacy provides an incentive to learn more about the subject. As a result, someone with a high self-efficacy may not prepare sufficiently for a task. The findings from this study illustrate that these participants were dedicated in learning about their thoughts and feelings and highlights how self-determined motivation adds additional understanding to this phenomena.

There is evidence to support the assimilation/accommodation model of change (Hollon *et al.*, 1988; Stiles *et al.*, 1990), in that participants had integrated and incorporated their experience of guided self-help. Participants claimed that they had developed insight into their thoughts and feelings, which resulted in an understanding of their difficulties, leading them to change their relationship with their thoughts. However, this early experience of change suggests that change may have occurred before cognitive restructuring techniques were introduced (Fennell & Teasdale, 1987), as described by Beck and colleagues' (1979) theory of change. Additionally, this study also lends support to the compensatory skills model (Barber & DeRubeis, 1989) as opposed to the activation-deactivation model (Hollon *et al.*, 1988), because participants described how they still experienced mood disturbance. Higher levels of self-therapeutic activity occurred because the emphasis was centred on replacing negative thoughts with realistic thinking. The activation-deactivation model, on the other hand, predicts that patients would not have engaged in self-therapeutic activity because negative thinking would have been rare after the deactivation of negative schemata (Hollon *et al.,* 1988).

A number of participants used guided self-help in ways that fitted the compensatory skills model, for example, Ellie used problem-solving and Margaret used planning to reduce negative thinking. Furthermore, as mentioned

previously, Teasdale (2000) argued that CBT delays relapse in depression by breaking the previously strong connections between mood disturbance and the individual elaborating negative self-referrent cognitions from it, which emphasises how the participants developed a different relationship to their negative thoughts. Adam specifically referred to knowing he has to 'get ( ) out of the cycle', while Rosie and Emma spoke of knowing they must not dwell on negative emotions but react differently than they did to them in the past. For these participants, practicing guided self-help involves trying to stop mood disturbance setting in train large amounts of negative self-referrent cognitions. Self-therapy involves disrupting not only self-referrent cognitions but also negative patterns of behaviour. Margaret and Ellie, for example, spoke of effective self-help as not only thinking differently but also not withdrawing in the face of low mood. Therefore, they also engaged in activities. However, the cognitive shift envisaged by Teasdale (2000) was not one that was easily achievable. It was described as challenging to alter negative thinking to more positive thinking, which was developed during therapy.

4.1.4 Summary

Overall, this particular sample of participants held strong hopes and self-determined motivation to change prior to their experience of guided self-help, independent of preconceived expectations. The importance of expectations towards GSH has been highlighted within other research (e.g., Macdonald *et al*., 2007). However, this finding indicates that factors other than expectations can contribute to the uptake levels of guided self-help. Whilst the importance of motivation is well documented within other contexts, it is fundamental for the effectiveness of guided self-help, particularly because a major component of change involves the 'self'. As a consequence of motivation and autonomy, participants were able to initiate help and felt capable in confronting and overcoming difficulties. Through development of a therapeutic alliance with the GMHW which was described as reassuring and validating, participants developed insight that their thoughts and feelings were not reliable. They consequently experienced an understanding of their difficulties. Their experience of guided self-help increased their awareness of the connections between their thoughts, feelings, needs, and actions, the impact that others

make on them, and the impact they have on others. The role of the GMHW was to use various clinical interventions to focus a light on these factors (e.g., reflection of feeling, highlighting how thoughts influence feelings, helping them become aware of how they are misperceiving the motives of others). Despite the short-term nature of guided self-help, participants considered the support and guidance offered by the GMHW as crucial. This therefore supports the cognitive-behavioural model of change (Beck, 1976) which states the importance of the therapeutic relationship. However, it also illustrates that a therapeutic alliance can be an important component of change, even in the short-term. The combination of these factors therefore set the stage for what was considered by the participants as a positive outcome – an experience of change within skills, thoughts and self-efficacy. As already mentioned, these findings draw on a number of theories related to change (e.g., Bandura, 1977; Beck *et al*., 1979; Deci & Ryan, 1985) and overlap with previous studies (e.g., Macdonald *et al*., 2007; Rogers *et al*., 2004). They illustrate that motivation and autonomy, a therapeutic alliance and self-efficacy are important components within the experience of guided self-help. However, they also indicate that these components may be achieved within the short-term for people with mild symptoms of depression and/or anxiety, which until now, has not yet been highlighted. Patients were therefore involved in a change principle whereby they autonomously engaged in behaviour that may have been avoided and consequently experienced something positive.

4.2 Clinical Implications

The findings of this qualitative study cannot make factual claims about the aspects of guided self-help but it does have implications for the implementation of self-help strategies in primary care that incorporate patients' perceptions of help-seeking and use of self-help. Greater success in implementing self-help interventions is likely if understandings elicited from patients are incorporated into the design and implementation of such interventions (Glasman, Finlay, & Brock, 2004). Moving the balance towards people's desire for rebuilding their own self-reliance might be better understood if prior information was available about the process of guided self-help. Additionally, patients may benefit from reading 'recovery stories' which could be

shared via those who have already experienced guided self-help. Additionally, GPs could contribute important information at the point of referral. For example, during referral consultations with patients, GPs could routinely introduce the importance that individuals have in producing a desired change. This study highlighted that help-seeking within primary care and referral information provided by GPs might miss opportunities for reinforcing a focus on self-efficacy. Primary care professionals could reinforce the philosophy of self-efficacy by being explicit about the purpose of self-help and describing how self-help approaches differ to other interventions such as, counselling and psychological therapy.

Taking other theoretical and empirical considerations into account, it is important to acknowledge the importance that the therapeutic alliance has in either nurturing or thwarting the natural process of change. These participants have highlighted aspects of the therapeutic relationship that they perceived were necessary for engagement with therapy and their positive experience. Guided self-help places less emphasis on the therapeutic relationship, and therefore sees the individual as the locus of change (as opposed to the environment). This study shows that by adopting a role that is facilitating, supporting, accepting and promoting, rather than changing, programming and managing, the facilitator can offer a process where more meaningful therapeutic change can occur for the individual (Deci & Ryan, 1985). According to SDT, the process of therapy is "facilitated by the therapists' disciplined approach to being autonomy-supportive and providing the need-related nutriments of structure and involvement that allow the integrative propensities within clients' to become active" (Ryan & Deci, 2008, p. 190). Additionally, for this sample of participants, feelings of self-efficacy were strengthened when they worked collaboratively with the GMHW, further highlighting the importance of establishing a strong therapeutic alliance and collaborative working.

With study findings illustrating that guided self-help is a dynamic process, this carries major implications both for the within-session delivery of guided self-help and for end-of-therapy planning. Whilst guided self-help was successful for this sample of participants, this information might be useful to understand when experiences of guided self-help are less successful. Attitudes towards managing their own mental health and the possibility of rotating between

needing fresh motivation and taking action after discharge would become an important focus of therapy. Facilitators may also need to acknowledge that self-management will be hard and might be associated with ongoing vulnerability to depression and/or anxiety. Other research findings have highlighted the importance of memory (Glasman *et al.*, 2004) and suggest that clinicians could consider giving patients audiotapes of their sessions, in addition to the workbooks that are already provided.

4.3 Strength and Limitations

One of the limitations of this study is that participants were interviewed about their prior expectations of guided self-help after its completion. Retrospective accounts can be at risk of bias because, in reference to this study, participants' accounts were provided with the benefit of hindsight and may have been 'rose-tinted' as a result of their positive outcome. This may have also been influenced by interviews being held in close succession to completion of guided self-help. Participants' subjective views are also liable to change over time (Macdonald *et al*., 2007) and collecting longitudinal data might be more appropriate for contexts such as therapy processes. However, because this approach has allowed participants to talk about their direct experience with guided self-help, it is hoped that the accounts have provided an overview of how guided self-help has impacted upon them and how they have adapted in order to effectively manage the symptoms of depression and/or anxiety.

Participants entered this study out of choice by returning a reply slip to the researcher and as a result, are a self-selected sample. It is important to remain aware that the findings of this study therefore represent a particular biased sample, whereby all participants presented as hard working, high achieving and dedicated individuals who live within a privileged PCT area. Consequently, the sample did not include patients from lower social classes or ethnic minorities, or patients who declined/dropped-out of guided self-help. Despite this, the participants offered in-depth accounts about their motivation to manage symptoms of depression and/or anxiety and illustrated how guided self-help influenced that process.

There are identifiable strengths inherent in IPA. It is a flexible, adaptable and increasingly popular approach. It is a methodology with strong theoretical connections and purpose combined with a systematic approach to analysis (Smith & Osborn, 2008; Brocki & Wearden, 2006). The staged analysis process facilitates the exploration of issues pertinent to individuals and the analysis process enables researchers to make interpretations according to their own theoretical or scientific background. There are some limitations noted in the literature. In general, qualitative methods facilitate in-depth exploration, but reduce the ability to generalise findings. Small numbers of participants may not be representative of the wider population and larger sample sizes involve time-consuming analysis. Although the process used in many qualitative analyses is painstaking and iterative, a researcher may never completely feel that this process is exhausted. Despite the assertions that IPA narratives are a co-construction between researcher and participant, there is the possibility that the researcher may formulate what is a legitimate, albeit different, account to a participant due to the nature of the researcher's epistemological background. Finally, there is the issue of 'bracketing', the process by which one is aware of theoretical assumptions being, hypothetically, put to the back of one's mind. Clinicians who conduct IPA research are encouraged to consider this process, but may find it particularly difficult. Reynolds (2003) believed that bracketing is almost impossible. It is very difficult to set aside pre-existing assumptions or knowledge when the analysis is dependent on theoretical interpretation.

Brocki and Wearden (2006) highlighted how a lack of advice about how much the researcher should interact with the participant or start to interpret data within the interview has led to variations in the amount, quality and depth of information provided. Willig (2008) also raised concern that IPA is unable to provide causal explanations of a particular phenomenon. However, it is argued here that this is not the focus of qualitative research and that IPA is one way of contributing to an enhancement of the knowledge about a phenomenon. Despite some potential limitations, one of the strengths of IPA is its recognition that contextual factors influence how meaning is constructed by an individual. It is argued that this results not only in unique experiences being uncovered but also in revealing the shared aspects of an experience across individuals that result from the 'external forces within a culture' (Shaw, 2001, p. 49).

A further limitation exists in the language participants use to describe their perceptions. Most experiences in life are felt and understood (i.e., perceived) without having to be vocalised to another person. There is undoubtedly some meaning lost in the action of making sense of and vocalising experiences to a phenomenological researcher. A real danger is that experience is being constructed through language and not simply described through language (Willig, 2001). This is a limitation of many qualitative methodologies; however, it is particularly relevant to IPA with its focus on people's experiences of realities.

Regardless of these limitations, IPA has provided a useful tool for the study of peoples' perceptions and experience of guided self-help. Once again, the aim of the methodological approach was not to identify 'the truth', but instead to allow particular phenomena to be understood in a bid to contribute to the established knowledge of such phenomena.

4.4 Future Research Considerations

Further qualitative research might contribute to greater understanding of those aspects of guided self-help that participants' experience as related to a reduction in distress. The current research highlighted combinations of elements of guided self-help that individual participants perceived were necessary for their positive experience. Future research might further highlight whether these clusters of particular aspects are experienced by a greater number of participants as relevant to their experience by conducting a randomised controlled trial. This would ascertain whether these particular aspects led to a measurable reduction in distress for clusters of participants.

Furthermore, there are multiple ways to examine client experience in psychological therapy (Elliott & James, 1989). Basing the analyses on single interviews may underestimate the degree to which participants subjective views change over time (Williams & Healy, 2001), and longitudinal data collection may be appropriate in the psychological therapy context (McKenna & Todd, 1997).

A cognitive-behavioural approach is prominent in both depression and anxiety and is the leading evidence-based treatment, which focuses on outcomes (NICE, 2004). Whilst CBT states that it is important for the therapist to develop rapport with the patient, further research to understand effective

implementation of the therapeutic alliance within guided self-help would be beneficial. SDT explicitly emphasises autonomy-support and relatedness (Ryan & Deci, 2008), however more research into its theoretical development and how this can be integrated within CBT is required.

Engagement of patients is predicted by patient perceptions that they sought help because they identified with the goals of treatment and made a personal choice to attend guided self-help. Further research may benefit from considering how policies and programs can facilitate such identified motivation among clients. Self-determination theory proposes that identified motivation is facilitated when social contexts support patients' need for autonomy by taking their perspective, minimizing external controls, and providing opportunities for exercising choice (Deci & Ryan, 2002: Markland, Ryan, Tobin, & Rollnick, 2005).

Quantitative research will also examine whether people maintain self-management of their symptoms. Variables that could be measured include: the patients use of specific and/or adapted skills and strategies, self-efficacy beliefs, beliefs about vulnerability to depression and/or anxiety, therapeutic alliance and possible limits to CBT. This could help answer whether patients within a stepped-care model would need to access further resources in the future.

4.5 Reflective report

This section will provide discussion about particular issues raised by the research, which include: nature of interviews, the role of researcher and clinician and the use of inductive vs. deductive methodology. There will also be a section of reflexivity.

4.5.1 Nature of interviews

It has been claimed that an 'interview society' exists (Atkinson & Silverman, 1997) and consequently, interviews are used in 90 percent of social scientific research (Briggs, 1986). The widespread appeal of the interview has been attributed to its versatility, affording application to both qualitative and quantitative methodologies, and to a variety of epistemological perspectives, from realist approaches, which treat interview accounts as forms of testimony, to constructionist approaches, which treat the interview conversation as a site of

negotiation and co-construction of meaning between interviewer and interviewee (Hammersley, 2003; Smith, 1995). These approaches to interviews will be discussed here in more detail.

The aim of interviews for positivists is to generate 'facts' which are held independently from the research setting and the interviewer. The fundamental premise to this approach is that stable, essential facts about the world exist (Maseide, 1990), and it is these facts that are elicited through questioning in the interview, which come in the form of statements about the interviewee's beliefs (Silverman, 2001). Therefore the most important task in the interview process for positivists is to design the most 'effective' and 'unbiased' methods so that the interview can discover information about reality (Biemer *et al.,* 1991). However, this approach has been criticised for variability in the delivery of questions between the prescribed question and the actual production by the interviewer. Such a deviation from the script can be highly problematic (Houktoop Streestra, 2000). Even researchers who adopt realist perspectives may argue that the 'organized social discourse' (Mishler, 1986, p. 119) of the interview interaction needs to be considered when approaching analysis (Mathieson, 1999).

For 'emotionalists', interviews are about 'symbolic interaction' and Silverman proposes an 'interviews-as-local-accomplishment approach' (2001, p. 104), where the interest focuses upon how interviews function as opposed to what they are about. The role of the interview in this approach therefore differs to that of positivists in that both interviewer and interviewee are treated as 'subjects', rather than as information emitting 'objects'. Consequently, a more humanistic version of the interview is preferred by emotionalists and they believe that interviewers should attempt to create an open and accurate communication (Holstein & Gubrium, 1997), where they make efforts to encourage the interviewee out of that role and share their 'lived experience'. Consequently, an emotionally involved interview is seen as an ideal outcome. However, whilst the emotionalist approach has good intentions (Reason & Rowan, 1981), Silverman (2001) criticises that the approach overlooks critical aspects of the interview. He suggests that the 'openness' of the question design and the little involvement of the interviewer may create an interpretative problem because of constraints being placed on the answers. Furthermore,

even though emotionalists criticise positivists, the assumption that emotionalists make about interviewers being able to manipulate the interviewee's responses, resonates with positivist assumptions (Silverman, 2001).

Constructionalists on the other hand differs to the views of both positivists and emotionalists and rejects the assumption that they both take for granted, which is the pre-existence of 'truth' or 'real subject' outside the interview (Kvale, 1996). Radical constructionists go on further to suggest that there is no reality in the social world that can be obtained from an interview (Miller & Glassner, 1997). Constructionalists therefore attempt to consider what happens in interviews as a topic in its own right, not as a method which enables researchers to gain facts. Essentially, constructionalists present the knowledge and meaning which is actively created through the interview (Holstein & Gubrium, 1997). However, the radical stance in particular has been criticised for its narrow focus on the conversational skills of the participants in the interview. Furthermore, there is a lack of value to treat interview data as informative about any other reality other than the interview itself (Silverman, 2001).

Researchers adopting the perspectives of discursive psychology and conversation analysis emphasise the need to take account of the productive role of the interviewer in the ongoing talk (Potter & Wetherell, 1987, 1995) and of the ways in which interview conversations may be structured by local conventions, in which the interviewer is expected to ask questions, and the interviewee's role is to answer rather than ask (Schegloff, 1992).

The positioning of the interviewer in relation to the respondent is also a key concern in research. As Baker (1997, 2003) notes, most participants are selected for study on the basis of being members of a particular category, for example in this case, people with mild to moderate depression and/or anxiety who have completed guided self-help within a stepped-care model. Therefore an interview can be approached exploring how these identities are accomplished, and the participants' interest of their respective category entitlements to knowledge and experience (Antaki & Widdicombe, 1998). Song and Parker (1995) have found that the interviewee's assumptions about the interviewer's cultural identity may be central to what is disclosed and the manner in which it is done, and as such have argued for more work on how interviewees position and construct interviewers, and how interviewers respond

to and negotiate such positioning. Even when they are given clearly presented guidelines, it is unlikely that the interviewee would have been in a similar situation before, one in which they are the exclusive focus for a considerable amount of time, with a possible expectation that they should 'tell their story' in-depth. Interviewers must decide how to present themselves, which is dependent on who is being interviewed and where (King, 1996). Reinharz (1992) argued that interviewers may consciously desire to either 'down play' or 'play up' to their professional status, depending on who they are interviewing. However, Oakley (1981) suggests that interviewers are required to have openness, engagement and a striving for intimacy. Nonetheless, a decision about how to present oneself as an interviewer still needs to be made as this leaves a profound impression upon the participants and can influence how successful the study will turn out to be (Fontana & Frey, 1994).

Furthermore, interviewees place a certain level of trust in the interviewer. Depending on where the interview is held, interviewees may be ostracised by their peers for talking (Patton, 1990). There may also be a certain level of intrusion in their life, for example, the intellectual and emotional demands of completing an interview, and for some interviewees, they may say things that they never intended to. Despite how interviews are managed, it is important to acknowledge that interviews will raise strategic, personal and ethical issues, and will vary according to the focus of the study (King, 1996).

4.5.2 Researcher vs. Clinical Role

Much qualitative research is dependent upon the perception of one person (the interviewer) of a situation at a given point in time, and that perception will be shaped by personality and the nature of the interaction between those in the interview (Punch, 1994). In-depth interviewing can also invoke powerful emotions relating to unresolved past or current events and these can increase the interviewees' vulnerability (Hutchinson, Wilson, & Wilson, 1994; West, 1994). Therefore interviews have ethical implications and much responsibility is placed on the interviewer, where there is a need for adequate training in interviewing skills and techniques, and awareness about the psychological processes associated with in-depth interviewing (King, 1996).

Consequently, comparisons can be drawn between research interviews and clinical interviews.

It is suggested that a research interview does not represent a counselling situation, as it is not considered appropriate to offer therapeutic interventions when conducting research is the primary goal (King, 1996). Instead, it is seen that participants are there to help the interviewer, although their reasons for participating may vary. Hutchinson and colleagues (1994) characterised participants' involvement in health research as the desire or intention to achieve self-acknowledgement, self-awareness, catharsis, empowerment or a sense of purpose. Such intentions are likely to be varied according to the participants level of interest invested in the research topic, but they are seen to be closely related to the fundamental aims of counselling. Knowledge of these aims and acquired counselling skills can therefore enhance the interviewer's understanding of themselves as research instruments. Furthermore, reflexive accounts and analyses can raise conscious awareness of the choices made during an interview in order to affect control and direction (King, 1996).

McLeod (1993) outlines the essential aims of counselling as: enabling the client to develop insight, self-awareness and acceptance, helping the client bring about cognitive, behavioural or social change, and helping the client experience empowerment. For example, McLeod (1993) suggests that self-awareness and even acceptance may occur as a result of the evolving narrative during in-depth interviewing, and a consequence of such inquiry can be a strengthened sense of self, which implies change (West, 1994). The extent to which these aims apply to a research interview depends upon the nature and format of the interview, as well as the interviewees involved. However, despite the interviewing method or perspective adopted, the use of basic counselling skills can be useful in maximising the interviewer's understanding of the interviewee's experiences and feelings (McLeod, 1993).

The features mentioned above originated largely from a humanist approach, which proposed that three 'core conditions' were necessary for a counselling relationship to be successful: empathy, genuineness and unconditional positive regard (Rogers, 1951). Empathy is specific and requires that the interviewer should be sensitive to the changing experience of the interviewee, be able to enter the other person's world as far as is possible, and

to be able to communicate that understanding to the interviewee. Genuineness involves direct and open communication and is closely related to unconditional positive regard, which implies acceptance of the other person.

These core conditions originally specified by Rogers (1951) can be usefully applied in research interviews through the employment of active listening skills such as, paraphrasing which communicates an empathic understanding of the participants' thoughts, experiences and feelings; reflecting which provides further opportunity for the interviewee to confirm, modify or reject the interviewer's understanding of what has been stated; summarising which can be used in conjunction with reflection and draws together the essence of what the interviewee has said; and open questioning. However, this contrasts with the model proposed by McCracken (1988) who argued that active listening strategies should not be employed because they are 'obtrusive' by violating the 'law' of non-direction and prevents interviewees from telling their story in their own terms.

It seems therefore that different types of interviewing are suited to different situations depending, among other things, on the researcher's epistemological and political leaning. The domain of the personal is a difficult and potentially emotionally disturbing area to unload (West, 1994) but feelings and constructions are a large part of the research experience. Consequently, rather than just being methodological, interviewing acknowledges deeper levels which are related to the self and others, and in learning about the other, people can learn about the self (Fontana & Frey, 1994).

4.5.3 Inductive vs. deductive methodology

Quantitative or qualitative studies can be distinguished by a set of assumptions, principles, and values about truth and reality. Quantitative researchers accept that the purpose of science is to discover the truths that exist in the world and to use scientific method as a way of building a more complete understanding of reality (Thorne, 2000). Although some qualitative researchers work from a similar philosophical position, most recognise that in terms of human experience, it takes place in subjective experience, in social context, and in historical time. Therefore, qualitative researchers tend to be more concerned with discovering knowledge about how people think and feel

about circumstances, rather than creating judgments about whether those thoughts and feelings are valid (Thorne, 2000).

What makes a study qualitative is that it employs inductive reasoning processes to interpret and structure the meanings derived from data (Holloway, 1997). Distinguishing inductive from deductive inquiry processes is an important step in identifying what counts as qualitative research. Generally, inductive reasoning uses the data to generate ideas/hypothesis, whereas deductive reasoning begins with the idea and uses the data to confirm or negate the idea/hypothesis (Holloway, 1997). In actual practice, however, many quantitative studies involve much inductive reasoning, whereas good qualitative analysis often requires access to a full range of strategies (Schwandt, 1997). A traditional quantitative study in the health sciences typically begins with a theoretical grounding, then takes direction from hypotheses or explicit study questions and uses a predetermined set of steps to confirm or refute the hypothesis. This approach can then add evidence to the development of specific, causal, and theoretical explanations of phenomena (Thorne, 2000). Conversely, qualitative research takes the position that an interpretive understanding is only possible by way of uncovering or deconstructing the meanings of a phenomenon. Therefore, a distinction between explaining how something operates and why it operates in the manner that it does may be a more effective way to distinguish quantitative from qualitative analytic processes (Schwandt, 1997).

4.5.4 Reflexivity

An important element of qualitative research is the role of the researcher and what they bring to the study via their personal beliefs and experiences. Accordingly, it was my reflections upon the treatment of depression and anxiety that developed a general curiosity about peoples' help-seeking behaviour and the impact that such an intervention can have upon an individual.

In relation to this study, I had a general curiosity about the effectiveness of guided self-help for depression and anxiety. Having worked as a support worker in a guided self-help clinic, I had a willingness to understand how people actually experienced it. There is a plethora of quantitative research which has reported the effectiveness and efficacy regarding this intervention but what are

the factors involved in the experience that actually influence its effectiveness? Do expectations govern peoples' experience of guided self-help and if so, what are they? The hope behind this research therefore was to offer a more detailed understanding about peoples' expectations and experience of guided self-help. As already mentioned, my relationship to this study is as an outsider trying to understand how guided self-help is experienced and whether improvements could be made to make the experience better. Personally, I have particular concern for people who have depression and/or anxiety and feel positive about how treatment is shifting from prescribing medication for these conditions, with psychological interventions becoming more widely acknowledged. However, I have some doubt about just how effective guided self-help is in terms of using CBT.

In this study, I also documented the experiences encountered at each interview, along with feelings at the time that may have affected the way the interview was conducted. For example, a couple of the participants had time constraints in relation to their work and there was an element of pressure for them to get their story told as concisely as possible. This therefore influenced me in terms of following up interesting avenues, or not.

With me being a young female, this may have influenced the dynamics during interviews. Particularly with the men, when reading through their transcripts there was a sense of strength and determination in the descriptions of their experience, and taking my professional status into consideration, there was also a sense of wanting to 'impress' with knowledge. Conversely, with the women, one lady in particular was incredibly shy and my professional status may have exacerbated this, making it difficult for her to answer some of the questions. This was illustrated throughout the interview as she would 'giggle' after most answers and seek reassurance about the content of her answers.

Any interruptions or the presence of anyone else in the homes of the participants was also noted, as were any significant gestures or experiences throughout the interviews that would not have been picked up by the tape recording. Initial potential themes were also highlighted at this stage of the analysis and the diary was a useful tool for beginning the analysis of full transcripts (which was often sometimes after the interview had taken place).

Furthermore, entries were made as and when thoughts about a topic arose (for instance, the paradigm and how to develop rapport with participants) or trying to analyse and resolve practical problems (such as possible ways to overcome recruitment difficulties). There was also a therapeutic aspect to writing down responses to difficulties encountered during the research process, using the privacy of the journal to "let off steam". Reviewing the journal entries revealed also how much detail about the process of carrying out research is quickly lost through forgetting, unless there is a simultaneous record of which to refer.

Through the process of writing a diary I was able to monitor the assumptions that I initially had about the study. Consequently, I found that my assumption of guided self-help being limited in its effectiveness was challenged by the participants' accounts and the meanings they had created for their experience. I was then able to discuss these challenges within the supervision process.

Examples of Diary Extracts

dd/mm/2009 – *First interview completed! Initial impression of Adam was that personality and 'drive to get better' prompted him to complete guided self-help. He appeared to be competitive, driven and determined – important factors for guided self-help? Throughout the interview Adam referred to buzz words related to psychology (wanting to impress with knowledge?). I found myself thinking about a potential 'weak link' between GPs and the guided self-help clinic – is this a reason why uptake rates are low? Could more be done?*

General feelings about the interview process? I think that there's a definite balancing act between counselling skills and interviewing techniques and I feel as though I may have made too many reflective statements? Note to self for the next interview!

dd/mm/2009 – Throughout the analysis process I have found that my initial assumptions have been challenged about guided self-help, particularly with this group of participants. I expected to find that guided self-help may have offered a

form of understanding about difficulties, but also felt that a lack of motivation (as expected in depression in particular) and therapeutic interaction may have prevented participants from experiencing a significant change. However, whilst these participants have indicated the opposite, I feel as though there are other factors to consider because surely everybody would be benefiting from guided self-help otherwise?! What is it about this group of participants that has made guided self-help so effective? Can it be bottled up and given to others who cannot find the motivation to help themselves?!

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APPENDICES

Appendix 1 – Participant Information Sheet

Nottinghamshire Healthcare NHS
NHS Trust

PARTICIPANT INFORMATION SHEET

Patients' Perception and Experience of using Guided Self-help for Depression and Anxiety in a Primary Care Setting

Name of researcher: Lisa Goodman

Introduction
We would like to invite you to take part in a research study. Before you decide whether to take part, you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully.

Purpose of the study
Increasing access to psychological therapies has become a key government priority over the past several years, as it was discovered that only a minority of patients in need, were able to receive therapy. As a result, 'guided-self help' has been introduced within primary care, to help increase access to psychological interventions for people with mild depression and anxiety. Furthermore, a number of studies have been conducted over the past several years looking at the effectiveness of guided self-help. This study aims to develop this information by understanding the patients' perception and experience of using guided-self help for depression and anxiety.

Why have I been invited?
You have been invited to take part in this study because you have received guided self-help for either depression or anxiety, and we would like to understand:
1. Your expectations of guided-self help before completing treatment.
2. Your experience of guided-self help.
3. The outcome of using guided-self help.

We will ask you to discuss your thoughts and feelings about your experience. If we can have a better understanding of patients' experience, then we can increase the knowledge of such an intervention, and its use in the future.

Do I have to take part?
It is up to you to decide. Taking part in the research is entirely voluntary. The study will be described to you and the information sheet will be explained, which will then be given to you. You will be asked to post a reply slip to the researcher indicating whether or not you agree to take part in the study. You are free to withdraw at any time, without giving a reason. This will not affect the care you receive in any way. If you feel as though you do not want to take part in this study, you just need to indicate so on the reply slip that you send to the researcher.

What will happen if I take part?
If you agree to take part then the researcher will contact you to arrange an interview. The interview will be arranged at a time that is convenient for you, and will be carried out in a place that is most appropriate for you, either the clinic at Bassetlaw or at your home. Prior to the interview taking place you will be asked to

sign a consent form to indicate that you are happy for the interview to take place. You will be then asked some questions about your experience, which will take about one hour to complete at the most, and will be audio recorded.

What will happen to the information?
Your contact details will be collected to arrange a time and place to meet, but your anonymity will be entirely preserved. All information which is collected about you during the course of the study will be kept strictly confidential, and the Data Protection Policy and guidance will be fully adhered to. The information gathered from the meeting will be transcribed and analysed to look for common themes within patients' experience of guided-self help, and direct quotations from the interview will be used when reporting the results. However, any identifiable information will be removed. Your name will not be used on the interview transcript or with any of the quotations used, and the audio tape will be destroyed once the write-up is completed. This study is being undertaken towards an academic qualification and the results will be written up and submitted for publication in a peer-reviewed journal.

Who has reviewed the research study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Derbyshire Research Ethics Committee.

Will there be any follow up of the research study?
At the end of the interview you will be asked whether you would like to receive a brief written summary of the study results. This will be available if requested.

Further information and contact details:
If you have a concern about any aspect of this study, you should ask to speak to the researcher or the researcher's clinical supervisor who will do their best to answer your questions. If you are unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the NHS Trust.

Researcher: Lisa Goodman Supervisor: Rachel Sabin-Farrell

Tel: 0115 8466646 Tel. 01623 784910

Email: lwxlmg1@nottingham.ac.uk

Please return completed reply slips to,

Lisa Goodman
Institute of Work, Health & Organisation
The University of Nottingham
International House, Level B
Jubilee Campus
Wollaton Road,
Nottingham
NG8 1BB

Appendix 2 – Reply Slip

Nottinghamshire Healthcare NHS
NHS Trust

REPLY SLIP

Patients' Perception and Experience of using Guided Self-help for Depression and Anxiety in a Primary Care Setting

Please indicate whether you would like to take part in this study by ticking the appropriate box.

Name:……

- I would **like** to take part in this study ☐
- I would **not like** to take part in this study ☐

If you have stated that you would like to take part in this study, could you please complete the information below. This information will be kept strictly confidential. If you have stated that you do not want to take part in this study, then you do not have to complete this information.

Age:……..

Gender (Please tick appropriate box) Female ☐

Male ☐

Address:

Telephone Number:

Number of guided self-help sessions completed?.....

Number of workbooks completed?.....

How long has it been since your last guided self-help session?.....

Appendix 3 – Consent Form

Nottinghamshire Healthcare NHS
NHS Trust

Study Number:
Patient Identification Number:

Institute of Work, Health & Organisation
The University of Nottingham
International House, Level B
Jubilee Campus
Wollaton Road,
Nottingham
NG8 1BB

PARTICIPANT CONSENT FORM

Study Title: Patients' Perception and Experience of using Guided Self-help for Depression and Anxiety in a Primary Care Setting

Name of researcher: **Lisa Goodman**

If this is right, please initial the box

- I confirm that I have read and understand the Information sheet dated 07/11/08 (version five) for the above study. ☐
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that taking part in the study is voluntary and my choice. ☐
- I understand that I can stop taking part in the study if I want to, without my medical care being affected. ☐
- I agree to the interview being audio taped ☐
- I understand that anonymised direct quotes may be used in the study write up ☐
- I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Person taking Consent	Date	Signature

Appendix 4 – Semi-Structured Interview

Semi-structured Interview Schedule

A. Expectation

1. Had you heard about guided self-help before being referred?
2. What were your expectations of guided self-help?
3. Before starting guided self-help, what was your understanding of it?
4. Before starting guided self-help, how did you feel about it?
   Prompt: What were you hopes about doing guided self-help? What were your concerns about doing guided self-help?

B. Experience

5. What was your experience of having/doing guided self-help?
   Prompt: Positive or negative? How did you feel when you were having guided self-help? What were the most/least helpful aspects of guided self-help? Were your expectations of guided self-help met?
6. Now that you have experienced guided self-help, how would you describe it to a friend?
7. How did you feel about sharing your experience with family/friends?
   Prompt: Did you talk to family and friends? Were you provided with support?

C. Changes

8. What do you think/feel about guided self-help now?
9. Have there been any changes as a result of experiencing guided self help?
   Prompt: Positive or negative?
10. How will the experience of guided self-help benefit you in the future?

- Can you tell me more about…?
- Can you think of an example…?

Appendix 5 – Ethical Approval Letter

Derbyshire Research Ethics Committee
3rd Floor
Laurie House
Colyear Street
Derby
DE1 1LJ

Telephone: 01332 868765
Facsimile: 01332 868930

13 November 2008

Miss Lisa M Goodman
Trainee Clinical Psychologist
Derbyshire Mental Health Services NHS Trust
c/o University of Nottingham, I-WHO,
International House, Level B,
Jubilee Campus, Wollaton Road, Nottingham
NG8 1BB

Dear Miss Goodman

Full title of study: **Patients' Perception and Experience of using Guided Self-help for Depression and Anxiety in a Primary Care Setting**

REC reference number: **08/H0401/123**

Thank you for your letter of 07 November 2008, responding to the committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the committee by the Vice Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.
Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*	
Application	5.6	17 September 2008	
Covering Letter		30 June 2008	
Investigator CV			
Dr Shirley Thomas CV	2	17 September 2008	
Interview Schedules/Topic Guides	3	07 July 2008	
Participant Consent Form	3	07 November 2008	
Participant Information Sheet	5	07 November 2008	
Peer Review		24 July 2008	
Protocol	7	14 July 2008	
Reply slip	1	07 November 2008	
Response to Request for Further Information		07 November 2008	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view if the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0401/123	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Mr Phil Hopkinson

Vice Chair

Email: jenny.hancock@derwentsharedservices.nhs.uk

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: *Dr John Sykes*
[R&D Department for NHS care organisation at lead site]

Appendix 6 - British Journal of Clinical Psychology: Notes for contributors

British Journal of Clinical Psychology (BJCP)

Notes for Contributors

The **British Journal of Clinical Psychology** publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via our online peer review system. The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations

indicated in the text.

- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. Please see the document below for further details:

British Journal of Clinical Psychology - Structured Abstracts Information

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Publication ethics

All submissions should follow the ethical submission guidelines outlined the documents below:

Ethical Publishing Principles – A Guideline for Authors

Code of Ethics and Conduct (2006)

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library

Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

8. Copyright

On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form. To find out more, please see our Copyright Information for Authors.